ARTICLES

THE TECHNICAL AND CONCEPTUAL FLAWS OF MEDICAL MALPRACTICE ARBITRATION

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I. INTRODUCTION

Given the long, successful history of arbitration as an alternative to litigation,[1] it was no great surprise when the concept was pressed into service in the medical malpractice context. The Commission on Medical Malpractice, under the general direction of the United States Department of Health, Education and Welfare, first suggested the feasiblity of this latest utilization of arbitration in 1973.[2] According to the Commission, however,

> [i]t became increasingly clear . . . that there was a paucity of basic knowledge, not only on the process of arbitration, but also on the results. *It was obvious that many persons and organizations who had not analyzed the true characteristics of arbitration nevertheless believed that it was a method of dispute settlement that would make a major contribution to solving the malpractice crisis.*[3]

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1. *See generally* F. ELKOURI & E. ELKOURI, HOW ARBITRATION WORKS 2-3 (4th ed. 1985); G. WILNER, DOMKE ON COMMERCIAL ARBITRATION § 3.01-4.03 (rev. perm. ed. 1985); Mentschikoff, *Commercial Arbitration*, 61 COLUM. L. REV. 846, 854-56 (1961).

2. *See* DEP'T OF HEALTH, EDUCATION & WELFARE, THE REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, DHEW Pub. No. (OS) 73-88 (1973) [hereinafter cited as REPORT]. California health care provider practice preceded such public comment. *See* Heintz, *Arbitration of Medical Malpractice Claims: Is It Cost Effective?*, 36 MD. L. REV. 533, 535-40 (1977); Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947, 958-59 (1972).

3. REPORT, *supra* note 2, at 91-92 (emphasis added).

Indeed, the goals of those proposing medical malpractice arbitration must be examined closely. Lip-service may have been paid to the two traditionally claimed advantages of arbitration over litigation—speed and economy.[4] The push for the arbitration of malpractice claims, however, must not be seen as linked to the general interest in alternative dispute resolution mechanisms exhibited over the past two decades. This examination of alternative mechanisms has had as its primary goal the identification of fora and procedures suitable for the resolution of meritorious claims that, for essentially economic reasons,[5] had been excluded from the litigation system. In direct contrast, malpractice claims have always been guaranteed judicial resolution because of the contingency fee system.[6] Furthermore, unlike commercial and labor areas, there is no evidence that the patient-provider relationship has evolved to a stage that would make self-governance, and hence arbitration, appropriate.[7]

There are two primary goals set forth by those propounding the arbitration of malpractice claims:[8] first, to chill attorney interest in what are labelled *vel non* as frivolous or unmeritorious claims; and second, to reduce the size of damage awards in meritorious claims.[9]

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4. *See, e.g.*, Sakayan, *Arbitration and Screening Panels: Recent Experience and Trends*, 17 FORUM 682, 684-85 (1982). A third potential advantage that arbitration may hold over litigation is the potential subject-matter expertise of the arbitrator.

5. For example, the size of the claim or the financial means of the claimant. *See, e.g.*, 1 ACCESS TO JUSTICE, pt. 1, chs. II, III (M. Cappelletti & B. Garth eds. 1978).

6. This may be a slight overstatement. First, a plaintiff will have to expend certain psychic and information costs en route to utilization of the contingency fee system. Second, the plaintiff's attorneys (the source of the up-front expenditure) will tend to filter out "unmeritorious" claims, or in other words, small claims with high litigation costs but without any long-term pro-plaintiff precedential value.

7. *See* Mentschikoff, *supra* note 1, at 848-52. *See also* text accompanying notes 114-18 and 155-62.

8. *See e.g.*, Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, in REPORT, *supra* note 2, 214, 297 app.

> To the extent that arbitration achieves public acceptance and provides the advantages which are attributed to it of a speedy and inexpensive claims resolution medium, its use must be encouraged. However, it is apparent from the literature that the major motivation behind establishing arbitration plans is to benefit hospitals, physicians, and, principally, the insurance industry, by privacy of proceedings and protection from large sympathy verdicts of juries for which safeguards already exist in the judicial process. It is also clear that its stated advantages of speed and economy apply only to the hearing phase. Arbitration neither reduces the overall time required for claim resolution nor economizes greatly the preparation phase of the medical malpractice claim.

Id. Cf. Coulson, *Arbitration of Medical Malpractice Claims*, 3 OHIO N.U.L. REV. 507 (1975) (a hearty endorsement of the medical malpractice arbitration concept by a past president of the American Arbitration Association).

9. *Cf.* Schnepple, *Arbitration: solution to malpractice dilemma?*, 48 HOSPITAL 41, 43 (1974) ("[L]arge sums may still be awarded based on the merits of the case.

Neither goal is related to providing a resolution for otherwise unresolvable claims. Both are intimately linked, however, to the widely held belief that the judiciary is unwilling or unable to exercise effective control over juries in civil trials.[10] It is further suggested that any claimant-group enthusiasm for arbitration involves a hope that arbitration will substitute for further statutory diminution of plaintiffs' procedural and substantive rights.

In the absence of any convincing empirical studies by which to judge malpractice arbitration,[11] the purpose of this Article is to analyze

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Arbitration is not necessarily a means of decreasing the size of judgments.") *See* Bedikian, *Medical Malpractice Act: Michigan's Experience with Arbitration,* 10 AM. J. L. & MED. 287, 291-92 (1984).

10. *See, e.g.,* Holden v. Rannick, 682 S.W.2d 903 (Tenn. 1984) When a trial judge approves the jury's verdict without comment, an appellate court must presume that he adequately performed his function as a "thirteenth juror." *Id. See also* Fowler v. Mantooth, 683 S.W.2d 250 (Ky. 1984) The functions of the trial and appellate courts differ when a question of excessive damages is at issue. The decisions of trial courts, based on jury verdicts, are presumed correct by appellate courts. *Id.* Contrast the position in England: Ward v. James, [1965] 1 All E.R. 563 (C.A.) (court of appeal removed most personal injury cases from jury determination).

11. For the limited data that do exist on the working of malpractice arbitration, see Bedikian, *supra* note 9, at 303-05; Heintz, *supra* note 2, at 535-51; Ladimer & Bush, *Is arbitration the answer to malpractice disputes?,* MED. WORLD NEWS, Jan. 26, 1976, at 38; Ladimer, Solomon & Mulvihill, *Experience in Medical Malpractice Arbitration,* 2 J. LEGAL MED. 433, 443-64 (1981); Note, *Medical Malpractice Arbitration: A Patient's Perspective,* 61 WASH. U.L.Q. 123, 153-55 (1983).

Some states that have enacted malpractice arbitration statutes have subjected them to empirical analysis. In 1975, the Michigan legislature passed the Michigan Malpractice Arbitration Act, which among other things provided for the formation of an Arbitration Advisory Committee. The Committee's Evaluation Subcommittee performed a study of the program in 1982-1983, concluding that arbitration of disputes involving medical malpractice does provide a cheaper and quicker forum for resolution than does the traditional jury system. Specifically, the subcommittee disclosed the following:

> In all 2,611 closed claims opened after January 1, 1976, and closed between June 1, 1978 and June 1, 1982 were analyzed. Of these, 1,159 were disposed of prior to formal filing either in the courts or with the American Arbitration Association. Sixty-three of the cases filed in court were resolved by formal trial. (This accounts for five percent of all claims filed in the courts and two percent of all claims closed in which there was no signed arbitration agreement.) The 36 formal arbitration hearings which took place during the study interval constitute 36 percent of all claims filed with arbitration and six percent of all closed claims involving a signed arbitration agreement. Plaintiffs [sic] were successful in 27 percent of court trials and 31 percent of arbitration hearings.
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> Using information claims data, and employing timeliness, cost and consistency of award as standards by which to measure the comparative performances of arbitration and litigation, the committee members found arbitration to be characterized by a shorter time from filing to disposition, lower expenses for defense of claims and more consistent awards.

Memorandum from Rhonda M. Powsner, M.D., J.D., to Saul Boyarsky, M.D., J.D.

critically from a conceptual perspective the arbitration systems that operate currently and to explore the technical legal problems they pose. Further, wider questions will be raised: first, whether this new approach to dealing with malpractice claims runs counter to the underlying philosophy of established arbitration and the accepted practical limitations to the function of the arbitrator; and second, whether the malpractice-specific arbitration systems that have been introduced truly comply with the core tenet of this alternate method of dispute resolution—its consensual, voluntary nature.

This Article is not a thinly veiled attempt to resurrect Judge Hays' infamous attack on established arbitration.[12] Neither should it be taken as a naive, pandering defense of the present, often excessive, system of malpractice litigation.[13] Instead, it is suggested that for conceptual and

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(May 10, 1985) (Dr. Powsner, a member of the Michigan Bar, discusses the Michigan medical arbitration program) (on file with the St. Louis University Law Journal).

Results of a different type were reached by the Ross-Loos Medical Group. In a study of closed cases in 1970-71, the Group concluded:

> First, for the physicians . . . arbitration is an unqualified success . . . .
>
> Second, for the defense the arbitration proceeding is economical . . . .
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> Third, both explicitly and by implication, the attorneys who were interviewed for this study seemed to agree on this point: The properly selected neutral arbitrator will be objective . . . .
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> Fourth, the existence of arbitration . . . has not promoted a plethora of suits . . . .
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> An additional conclusion might be made from this study: There is something to discourage the plaintiff's attorney in his pursuit of a claim. . . . The reason for this phenomenon is somewhat obscure, but . . . it may well have something to do with the attorney's comparatively greater skill at rhetorical device, as compared to his analytical ability when dealing with medical facts. Given a "handle" on a couple of jury-appealing facts in a malpractice case, his skill at advocacy may carry the day. But before an arbitrator, one assumes that the attorney must mainly win on the facts alone.

Rubsamen, *The Experience of Binding Arbitration in the Ross-Loos Medical Group,* in REPORT, *supra* note 2, at 424, 443-44 app. These conclusions were based upon an examination of only thirty-five cases, twenty-one involving attorneys. *Id.* at 428-42.

12. Hays, *The Future of Labor Arbitration,* 74 YALE L.J. 1019 (1965). In that article Judge Hays stated:

> I am forced to the conclusion, based upon observation during twenty-three years of very active practice in the area of arbitration and as an arbitrator, and from suggestions in the more intelligent literature in this field, that . . . arbitration has fatal shortcomings as a system for the judicial administration of contract violations.

Id. at 1034.

For a more recent critique of labor arbitration, see Goldberg, *The Mediation of Grievances Under a Collective Bargaining Contract: An Alternative to Arbitration,* 77 NW. U.L. REV. 270, 274-80 (1982).

13. *See, e.g.,* Burger, *The State of Justice, A.B.A. J.* April 1984, at 62 (criticizing the excesses and abuses that form the basis for much of today's lament about the legal profession).

I am as confused, skeptical, and unsure about the role of the traditional trial in

technical reasons, malpractice arbitration as currently envisaged is a dangerously inappropriate solution to the real or perceived malpractice crisis. As one commentator has put it, "for the negligently injured patient, blanket arbitration piles poor legal care on top of poor medical care."[14]

II. A TALE OF TWO CRISES

A. *The Malpractice Crises and Curative Legislation*

Medical malpractice arbitration is an American phenomenon[15] stemming from the so-called malpractice crises of the past decade. Thus, its role and its juridical foundations can only be appreciated within the context of these crises. In 1973, the Secretary's Commission on Medical Malpractice was forced to conclude that "there is no uniquely identifiable 'malpractice problem,' but rather, a complex of problems involving interacting medical, legal, sociological, psychological, and economic factors."[16] For many, however, this official imprimatur of "problem" was enough in itself; the complex, polycentric nature of the problem was ignored, empirical research eschewed. State legislatures in the 1970's simply declared that there was a malpractice "crisis," that the cause was medical malpractice law, and that the solution was "crisis" legislation designed to curb, delay, or otherwise frustrate the prosecution of malpractice claims.

Just as the passage of crisis legislation did not quash the debate over the reality of any crisis, neither did such legislation stem the tide of rising health care costs. Despite some evidence of a dramatic decline in the number of medical malpractice claims after the peak of the crisis in 1975,[17] there were no signs of any drop in the acceleration rate of malpractice premiums.[18] Furthermore, as the 1980's progressed, even the number of malpractice claims seemed, once again, to be on the

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our legal system as anyone (probably more so). *See, e.g.*, Leff, *Law and*, 87 YALE L.J. 989, 995-98 (1978). Further, while I admit (for want of clearer articulation or more sophisticated analysis) to a "plaintiff bias," I consider the holy grail of jury determination of civil cases to be, at best, of doubtful utility and, at worst, downright silly. I have chosen to mask my own uncertainties by incanting that old common-law standby, the burden of proof. Those who wish to replace the status quo with a new system must prove its advantages, be clear about their motives, and with specific regard to the adoption of an extant format such as *voluntary* arbitration, satisfy conceptual doubts about its literal transferability to the malpractice context.

14. Ladimer & Bush, *supra* note 11, at 52 (comment by Bush).

15. Compare and contrast the various "small claims" arbitration systems detailed in the "world survey" in 1 ACCESS TO JUSTICE, *supra* note 6.

16. REPORT, *supra* note 2, at 4.

17. N.Y. Times, April 19, 1983, at 8, col. 1 (reporting on a study by the Rand Corporation's Institute for Civil Justice).

18. In New York, for example, the State Superintendent of Insurance permitted a 52% increase in malpractice insurance premiums. *Id.*, Jan. 15, 1985, at A1, col. 2.

increase.[19] This increase, coupled with evidence that the size of malpractice awards and settlements was also on the increase, [20] heralded the appearance of a second malpractice "crisis."[21] As was the case in the first crisis in the 1970's, assertions that a second crisis is underway have not gone unchallenged. Commentators have critically scrutinized reports which advance the thesis that the average jury award far exceeds injuries actually suffered.[22] Other authorities have concluded that the increase in malpractice claims is a function of the growing incompetence within the medical profession itself.[23] Further, while the link between the rising costs of malpractice insurance and increased health care costs seems well established,[24] some have asserted that this represents only a "trifling percentage" of the rising overall costs of health care in the United States.[25] Various skeptics have even suggested that

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19. According to a report by the American Medical Association, the claim rate at the height of the malpractice crisis in 1975 was fewer than 5 per 100 doctors. By 1983, however, the rate had climbed to 16 claims per 100 doctors. *Id.*, Jan. 17, 1985, at 1, col. 6.

20. *Id.*

21. "The public fighting [between the American Medical Association and the Association of American Trial Lawyers] started a year ago, when the AMA proclaimed that a new medical malpractice 'crisis' had begun." *Tempers Flare Over Malpractice*, St. Louis Post-Dispatch, Feb. 18, 1986, at C1, col. 1. *Cf. Should lawyers' contingency fees be limited?*, U.S. NEWS & WORLD REP., Jan. 27, 1986, at 43 (interview with Peter Perlman, President of the Association of Trial Lawyers of America). Mr. Perlman stated:

> The so-called insurance crisis can be traced primarily to the drop in interest rates, which limits the investment income of insurance firms. There was no claim of a crisis in the late 1970s, when interest rates were high. Insurers were reducing their premiums to get a bigger market share. Rather than basing premiums on expected losses, they based them on expected investment return, and now that comes back to haunt them.

Id.

22. *See, e.g.*, Localio, *Variations on $962,258: The Misuse of Data on Medical Malpractice*, LAW, MED. & HEALTH CARE, June 1985, at 126.

23. For instance, the New York State Health Commissioner, Dr. David Axelrod, described the problem of physician incompetence as "overwhelming." N.Y. Times, Feb. 27, 1983, at E6, col. 2. He subsequently promised tighter regulation of professional standards and enforcement of sanctions against physicians found to be incompetent. *Id.*, April 3, 1983, at A1, col. 1.

24. *See, e.g.*, the study prepared for the American College of Obstetricians and Gynecologists. *Id.*, Sept. 11, 1983, at A18, col. 6.

25. Neubauer & Henke, *Medical Malpractice Legislation: Laws Based on a False Premise*, TRIAL, Jan. 1985, at 64, 65. *See also* Lacayo, *The Malpractice Blues*, TIME, Feb. 24, 1986, at 60. This author presents some interesting data:

> If doctors cry that between 1980 and 1984 the average malpractice award jumped 63% to $660,123, lawyers may retort that half of all awards made in that period were below an unchanging median sum of $200,000. [In 1980, the median sum was also $200,000.] The average annual charge for malpractice insurance coverage may have increased 79% between 1976 and 1984, but doctors' total income went up 89% at the same time.

the malpractice "crises" of the 1970's and 1980's are actually manufactured hoaxes perpetrated either by insurance companies attempting to increase profits,[26] or by physicians hoping to minimize external regulation of the medical profession.[27]

The validity of the above allegations or of possible alternative explanations for the existence of the medical malpractice crises is essentially irrelevant. It is all too clear that physicians, insurers, legislators, the media, and, as will be illustrated, now even the judiciary all believe in the existence of a 1980's crisis scenario. Further, these diverse groups believe that the crisis is directly linked to the state of contemporary medical malpractice law.

In general terms, the crisis legislation of the 1970's was designed to freeze the development of substantive medical malpractice law. Comparisons between this area of tort law and the development of the liability of manufacturers for product defects were all too easy to make. The courts nurtured products liability doctrine from a situation of nonliability,[28] through a period of negligence liability[29] (buttressed by *res ipsa loquitur*[30] and warranty[31] doctrines), to a strict liability regime[32] based in some states upon a sophisticated risk-benefit analysis.[33] Parallels to medical malpractice law were obvious. Progression in that area started from the original establishment of liability based on custom.[34] From that position came the painfully slow dismemberment of the "locality" rule[35] in favor of a national standard of care.[36] Next came the increasingly imaginative use of *res ipsa loquitur*[37] followed

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Id. Lacayo also graphically describes the base data used for his 79%–89% allegations. "Average insurance premium paid by doctors: 1976 – $4,700; 1984 – $8,400. Insurance premium paid . . . as a percent of . . . income: 1976 – 4.4%; 1984–4.2%." *Id.*

26. Baldwin, *The Phony Medical Malpractice "Crisis,"* TRIAL, Apr. 1985, at 4. *See also* Londrigan, *The Medical Malpractice "Crisis": Underwriting Losses and Windfall Profits*, TRIAL, May 1985, at 22; Sepler, *Professional Malpractice Litigation Crises: Danger or Distortion?*, 15 FORUM 493 (1980).

27. *See, e.g.*, Gesler, Aiken, Gleisner, Domnitz & Antoine, *Medical Malpractice: Eliminating the Myths*, 68 MARQ. L. REV. 259, 262-66 (1985).

28. Winterbottom v. Wright, 152 Eng. Rep. 402 (Ex. D. 1852).

29. *See* MacPherson v. Buick Motor Co., 111 N.E. 1050 (N.Y. 1916).

30. *See, e.g.*, Escola v. Coca Cola Bottling Co., 150 P.2d 436 (Cal. 1944).

31. *E.g.*, Henningsen v. Bloomfield Motors, 161 A.2d 69 (N.J. 1960).

32. Strict liability followed the case of Greenman v. Yuba Power Prods., 377 P.2d 897 (Cal. 1963) (en banc), and the publication of RESTATEMENT (SECOND) OF TORTS § 402A (1965).

33. *See, e.g.*, Barker v. Lull Eng'g Co., 573 P.2d 443, 457-58 (Cal. 1978).

34. Slater v. Baker & Stapleton, 95 Eng. Rep. 860 (K.B.D. 1767).

35. Small v. Howard, 128 Mass. 131 (1880).

36. *See, e.g.*, Morrison v. MacNamara, 407 A.2d 555 (D.C. 1979).

37. *See, e.g.*, Clark v. Gibbons, 426 P.2d 525 (Cal. 1967) (en banc); Quintal v. Laurel Grove Hosp., 397 P.2d 161 (Cal. 1964) (en banc); Ybarra v. Spangard, 154 P.2d 687 (Cal. 1944); Anderson v. Somberg, 338 A.2d 1 (N.J. 1975). *See also* Rubsamen, Res Ipsa Loquitur *in California Medical Malpractice Law—Expansion of a*

by flirtation with non-custom-based standards.[38] This in turn led to the expansion of the informed consent doctrine, designed to achieve compensation in cases in which the medical procedures themselves were not negligently performed.[39] Finally came the explicit judicial enthusiasm for the imposition of strict liability in medical malpractice cases.[40]

Although some state legislatures involved themselves in more comprehensive reforms, the typical 1970's crisis legislation seemed intent on retaining the traditional approaches to medical malpractice litigation.[41] The dominance of the custom standard was reaffirmed,[42] and in some states, forms of the locality rule received statutory endorsement.[43] Any further development of the *res ipsa loquitur* doctrine was denied by clearly maintaining the burden of proof on the plaintiff.[44] Moreover, some states mandated a custom (expert testimony) standard,[45] rather than a "need to know" test,[46] in informed consent cases.

There were two other salient features of the 1970's reforms that did not have a direct impact upon substantive malpractice law. First, many state legislatures changed the accrual date for the malpractice statutes of limitation from one based on the *discovery* of the malpractice, to one based on the *occurrence* of the injury-causing event.[47] Sec-

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Doctrine to the Bursting Point, 14 STAN. L. REV. 251 (1962).

38. *See, e.g.*, Darling v. Charleston Community Mem. Hosp., 211 N.E.2d 253 (Ill. 1965); Helling v. Carey, 519 P.2d 981 (Wash. 1974) (en banc).

39. *See* Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977).

40. *See, e.g.*, Johnson v. Sears, Roebuck & Co., 355 F. Supp. 1065, 1067 (E.D. Wis. 1973); Clark v. Gibbons, 426 P.2d 525, 535 (Cal. 1967) (en banc) (Tobriner, J., concurring); Helling v. Carey, 519 P.2d 981, 984 (Wash. 1974) (en banc) (Utter, J., concurring).

41. For detailed summaries of 1970's (and early 1980's) crisis legislation, see Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489 (1977); Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981); Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417. For a functional analysis, see Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939 (1984).

42. *See, e.g.*, WASH. REV. CODE ANN. § 4.24.290 (Supp. 1986) (legislative reversal of result in Helling v. Carey, 519 P.2d 981 (Wash. 1974) (en banc)).

43. *See, e.g.*, ARK. STAT. ANN. § 34-2614(A)(1) (Supp. 1985); VA. CODE § 8.01-581.20 (1984). *Cf.* ALA. CODE § 6-5-484(a) (1977) (statutory language "in the same general neighborhood" judicially modified into a national standard). *See* Zills v. Brown, 382 So. 2d 528 (Ala. 1980).

44. *See, e.g.*, ALASKA STAT. § 09.55.540(b) (1983); FLA. STAT. ANN. § 768.45(4) (West Supp. 1985); VT. STAT. ANN. tit. 12, § 1908 (Supp. 1985). But see OKLA. STAT. ANN. tit. 76, § 21 (West Supp. 1985) (Oklahoma legislature bucked the judicial trend and codified *res ipsa loquitur*).

45. *See, e.g.*, ARK. STAT. ANN. § 34-2615 (Supp. 1985).

46. *See generally* Annot., 88 A.L.R. 3d 1008, 1034 (1978 & Supp. 1985).

47. *See, e.g.*, ARK. STAT. ANN. § 34-2616 (Supp. 1985); IND. CODE ANN. § 16-

ond, some state legislatures experimented with provisions designed either to "chill" or delay litigation, or to encourage settlement, depending upon one's perspective. These mandated procedural hurdles that had to be cleared prior to the filing of a medical malpractice suit. Typical of this type of legislation were requirements of prior notice of intent to sue[48] and submission of claims to pretrial review or screening panels.[49]

Three critical features of the second malpractice crisis and resulting legislation unfold. First, the legislative emphasis has moved from containment of tort law to reforms designed to roll back tort law's reach and effectiveness in the medical arena. In this regard, and no doubt based on a belief that the judiciary has lost control over damage awards, there has been intensified interest among legislators to modify the traditional damage structure in malpractice cases. Examples of this tendency include the abrogation of the collateral source rule;[50] the institution of a periodic payments structure;[51] the elimination of specific monetary amounts from *ad damnum* clauses;[52] the introduction of a damage ceiling (or cap), either for noneconomic damages[53] or for damages generally;[54] and the modification of the attorney fee structure, ei-

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9.5-3-1 (Burns Supp. 1985); N.H. REV. STAT. ANN. § 507-C:4 (1983). *Cf.* CAL. CIV. PROC. CODE § 340.5 (West 1985). California uses a dual approach which provides that the time for the commencement of action shall be (1) three years after the date of injury, or (2) one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. Alabama uses a similar approach with a two-year or six-month rule. See ALA. CODE § 6-5-482(a) (1977). The insurance industry similarly prepared itself for change by moving from occurrence to claims-made policies. *See* Abraham, *supra* note 41, at 492-93.

48. *See, e.g.*, ARK. STAT. ANN. § 34.2617 (Supp. 1985); CAL. CIV. PROC. CODE § 364(a) (West 1982); N.H. REV. STAT. ANN. § 507-C:5 (1983); VA. CODE § 8.01-581.2-A (1984).

49. *See, e.g.*, IND. CODE ANN. §§ 16-9.5-9-1 to -10 (Burns 1983 & Supp. 1985). *See also* Harlan, *Virginia's New Medical Malpractice Review Panel and Some Questions It Raises*, 11 U. RICH. L. REV. 51 (1976); Note, *The Massachusetts Medical Malpractice Statute: A Constitutional Perspective*, 11 SUFFOLK U.L. REV. 1289 (1977).

50. *See, e.g.*, DEL. CODE ANN. tit. 18, § 6862 (Supp. 1984); N.H. REV. STAT. ANN. § 507-C:7I (1983); R.I. GEN. LAWS § 9-19-34 (1985).

51. *See, e.g.*, ARK. STAT. ANN. § 34-2619(D) (Supp. 1985); CAL. CIV. PROC. CODE § 667.7 (West 1980); DEL. CODE ANN. tit. 18, § 6864 (Supp. 1984); N.H. REV. STAT. ANN. § 507-C:7IV (1983). *Compare* ALA. CODE § 6-5-486 (1977) (creating a simple stage payments structure without any provision for adjustment or cessation).

52. *See, e.g.*, ALA. CODE § 6-5-483 (1977); ARK. STAT. ANN. § 34-2618 (Supp. 1985); IND. CODE ANN. § 16-9.5-1-6 (Burns Supp. 1985); MASS. ANN. LAWS ch. 231, § 60C (Michie/Law Co-op. Supp. 1985).

53. *See, e.g.*, N.H. REV. STAT. ANN. § 507-C:7II (1977) ("non-economic losses"); OHIO REV. CODE ANN. § 2307.43 (Baldwin 1984) (general damages). Because of the traditional function of pain and suffering damages, this also may be seen as an attack on attorneys' fees.

54. *See, e.g.*, IND. CODE ANN. §§ 16-9.5-2-1 to -7 (Burns 1983 & Supp. 1985)

ther by introducing a sliding-scale for contingency fees[55]or by mandating that costs should follow the cause.[56]

Second, and as outlined below, a discernible shift is perceptible in judicial attitudes towards such "Crisis II" legislation. Third, there seems to be a growing interest in replacing the tort law system as the vehicle for adjudicating medical malpractice cases with various alternative dispute resolution systems. Several states have embraced arbitration as a device suitable for this purpose. Arbitration is supposedly quick, cost efficient, fair, and constitutional. Whether today's malpractice arbitration schemes in fact possess these advantages is the subject of this Article.

B. *Crisis Legislation in the Courts*

Both sets of crisis statutes have been subject to constitutional review [57] on grounds as diverse as equal protection, due process, denial of the right to a jury trial, access to the courts, special privilege legislation, and the separation of powers doctrine.[58] The most frequently used constitutional attack has focused upon the particular legislation's conformity with state and federal guarantees of equal protection. With regard to the constitutional review analysis employed in these cases, there has been little judicial dissent from the view that no fundamental rights[59] or inherently suspect classifications are at issue. Accordingly, there has been general agreement[60] that the appropriate standard of

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(five hundred thousand dollar total damages cap; one hundred thousand dollars per provider, excess liability payable from general fund); VA. CODE § 8.01-581.15 (1984) (one million dollar cap on all recovery). *See generally* Richards, *Statutes Limiting Medical Malpractice Damages*, FED'N INS. COUNS. Q. 247 (Spring 1982); Note, *Medical Malpractice Legislation: The Kansas Response to the Medical Malpractice Crisis*, 23 WASHBURN L.J. 566, 569-82 (1984).

55. *See, e.g.*, CAL. BUS. & PROF. CODE § 6146(a) (West Supp. 1986); DEL. CODE ANN. tit. 18, § 6865 (Supp. 1984); N.H. REV. STAT. ANN. § 507-C:8 I & V (1983); PA. STAT. ANN. tit. 40, § 1301.604(a) (Purdon Supp. 1985). Also, note the slightly different approach of IND. CODE ANN. § 16-9.5-5-1(a) (Burns 1983) (maximum attorney's fee is 15% of patient's award).

56. *See* FLA. STAT. ANN. § 768.56 (West Supp. 1985). *See also* MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06(e) (1984) (assessing costs to party rejecting pretrial review panel determination).

57. *See generally* Learner, *supra* note 41, at 151-205; Richards, *supra* note 54; Comment, *Medical Malpractice: A Sojourn Through the Jurisprudence Addressing Limitation of Liability*, 30 LOYOLA L. REV. 119, 121-37 (1984).

58. *See generally* Annot., 80 A.L.R. 3d 583 §§ 3-6, 8-11 (1977 & Supp. 1984) (damage caps and pretrial panels); Annot., 12 A.L. R.4th 23 (1982 & Supp. 1985) (contingency fee scales). In addition, see the cases cited in American Bank & Trust Co. v. Community Hosp., 683 P.2d 670, 677 n.10 (Cal. 1984) (en banc).

59. *Cf.* Kenyon v. Hammer, 688 P.2d 961, 975 (Ariz. 1984) (en banc) (holding that the right to bring a medical malpractice action is a fundamental right).

60. *Cf.* Carson v. Maurer, 424 A.2d 825 (N.H. 1980); Arneson v. Olson, 270

review for such crisis legislation is the rational basis or rational connection test.[61]

This suggested judicial trend may be explained on more than one ground. First, recent examples of crisis legislation have tended to curtail, not the judicial control of the malpractice process, but the plaintiffs' awards in actual malpractice cases. It may be suggested that, just as plaintiffs are less likely to be able to attack these statutes on the grounds that they deprive the litigant of due process, access to the courts, and the right to trial by jury, so also is judicial disfavor towards the legislation unlikely to be as predetermined. Second, there has been a notable (and, presumably, judicially noticed) nationwide legislative persistance in maintaining a barrage of crisis legislation. Even hostile courts have been hesitant to enter the debate over whether any malpractice crisis indeed exists.[62] These continuing waves of legislation must influence the judicial decisionmaking process.[63]

Current judicial responses to the medical malpractice crises may be illustrated and measured by an examination of the following four recent decisions of the Supreme Court of California: *American Bank & Trust Co. v. Community Hospital*, [64] *Barme v. Wood*,[65] *Roa v. Lodi*

N.W.2d 125 (N.D. 1978) (cases applying tests of intermediate "fair and substantial" relationship or close correspondence between classification scheme and legislative goals).

61. "[T]he statute must be upheld if there exists any conceivable set of facts under which the classification rationally furthered a legitimate legislative objective." Schwan v. Riverside Methodist Hosp., 452 N.E.2d 1337, 1338 (Ohio 1983) (citations omitted). *See also* Otero v. Zouhar, 697 P.2d 493 (N.M. Ct. App. 1984).

62. "In the absence of a 'suspect classification' or a 'fundamental right,' courts will not second-guess the legislature as to the wisdom of or necessity for legislation." Carson v. Maurer, 424 A.2d 825, 831 (N.H. 1980) (citations omitted). *See also* American Bank & Trust Co. v. Community Hosp., 683 P.2d 670, 679 (Cal. 1984) (en banc). *Cf.* Jones v. State Bd. of Medicine, 555 P.2d 399 (Idaho 1976) (remanded for factual determination of existence of malpractice crisis). Of course, if the contrary conclusion is reached that a "fundamental right" is threatened, any such legislative conclusions are "fair game." *See, e.g.*, Kenyon v. Hammer, 688 P.2d 961, 976-79 (Ariz. 1984).

63. For examples of the apparent judicial acknowledgment of the existence of a malpractice crisis, see American Bank & Trust Co. v. Community Hosp. 683 P.2d 670, 677-78 (Cal. 1984) (en banc); Johnson v. St. Vincent Hosp., 404 N.E.2d 585, 589-90 (Ind. 1980).

64. 683 P.2d 670 (Cal. 1984), *vacating* American Bank & Trust Co. v. Community Hosp., 660 P.2d 829 (Cal. 1983). Interestingly, the rehearing represented an abrupt about-face by the court on the question of equal protection. In the earlier hearing, the court had outlined the history of the medical malpractice crisis in California:

> The medical malpractice insurance industry in California had severe problems for many years because it had failed since 1957 to charge doctors premiums high enough to allow sufficient reserves to be set aside to meet future claims. By 1975, the crisis affected the public health of the state's residents. Because the number of malpractice claims and the dollar amount of judgments had risen sharply since 1968, insurers were paying out $180 for each $100 in premiums collected. As a result, they were either aban-

Medical Group, Inc.,[66] and *Fein v. Permanente Medical Group*.[67] These decisions upheld various provisions of California's Medical Injury Compensation Reform Act of 1975 (MICRA).[68] Specifically, these cases affirmed the constitutionality of legislation providing for the periodic payment of future damages, [69] the modification of the collateral source rule,[70] the limitations on contingency fees,[71] and a cap on

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doning the malpractice market or raising premiums by several hundred percent.

Nor could the medical profession afford to absorb these increases or to pass them on to their patients. Only 27,000 doctors in California carried independent medical malpractice insurance, and this small number could not absorb the entire increase. Moreover, because doctors received a substantial proportion of their fees from the government, they could only pass the increases on to a limited number of patients who paid their own expenses, and these patients were unable to shoulder the entire burden. Some physicians, believing that they could neither absorb the additional premiums nor pass them on to their patients, went on strike, and medical care in certain sections of the state came to a virtual halt.

The Medical Injury Compensation Reform Act [MICRA] . . . was the Legislature's response. Generally speaking, it addressed the problems by enacting reforms in three basic areas: medical quality assurance, medical malpractice insurance, and medical malpractice litigation . . . .

In the area of medical malpractice litigation MICRA directed its attention to four basic concerns: time limitations, damages, attorney's fees, and arbitration.

660 P.2d at 832 (footnotes and citations omitted).

With this backdrop, the court considered an equal protection claim pertaining to a MICRA provision permitting the periodic payment of "future damages" when those damages were $50,000 or more against a provider in a malpractice case. The court applied "the familiar rational-relationship test, which is used to test the constitutionality of economic regulations," in order to "conduct a serious and genuine inquiry into the correspondence between the [suspect] classification and the legislative goals." *Id.* at 837 (citations omitted). The plaintiff did not challenge the notion that the primary motivation of the legislation, the promotion of public health by the containment of medical costs, was proper. Instead, it challenged the factual assumptions underlying the statute, asserting that there was, in fact, no malpractice crisis and that the legislature's premise that the cost of medical care could be contained by a reduction in the premiums paid by hospitals was erroneous. *Id.* at 839-40. The court agreed with this latter assertion, finding the cost effect of premium reduction to be "negligible at best." *Id.* at 840. The provision was held to be unconstitutional.

In the rehearing, however, that view could be found only in the dissenting opinions, as the majority chose not to examine the factual basis for the provision. *See infra* notes 86-87 and accompanying text.

65. 689 P.2d 446 (Cal. 1984).

66. 695 P.2d 164 (Cal. 1985) (en banc).

67. 695 P.2d 665 (Cal. 1985) (en banc), *appeal dismissed*, 106 S. Ct. 214 (1985).

68. Medical Injury Compensation Reform Act of 1975, 1975 Cal. Stat. 3949 (2d Exec. Session) (codified with amendments in scattered sections of the California Code).

69. CAL. CODE CIV. PROC. § 667.7 (West 1980).

70. CAL. CIV. CODE § 3333.1(b) (West Supp. 1986).

noneconomic damages.[72]

The MICRA provisions were attacked on various constitutional grounds including due process,[73] right to jury trial,[74] the separation of powers doctrine,[75] and the first amendment.[76] Central to the disposition of each of the cases, however, were the equal protection challenges. All of these challenges failed by narrow majorities.[77] For a court so obviously divided on the issue of validity, there was basic agreement through the first three decisions that the appropriate level of review was the less than rigorous rational basis approach.[78] It was not until *Fein* that Justice Mosk, in his dissenting opinion, broke ranks and adopted an intermediate "fair and substantial" approach.[79] For the most part, then, it was on the application of the rational basis standard that the courts were divided.

The majority's opinion in these cases was accurately reflected in *American Bank*.[80] That court concluded that "since there was a rational and legitimate basis for the Legislature's decision to attempt to reduce insurance costs in the medical malpractice area and since [MICRA is] rationally related to that objective, the Legislature did not violate equal protection principles in limiting [MICRA's] application to medical malpractice actions."[81] In dissent, Chief Justice Bird decried

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71. CAL. BUS. & PROF. CODE § 6146 (West Supp. 1986).

72. CAL. CIV. CODE § 3333.2 (West Supp. 1986). Section 3333.2 was upheld in Fein v. Permanente Medical Group, 695 P.2d 665 (Cal. 1985) (en banc), *appeal dismissed*, 106 S. Ct. 214 (1985). *Fein* also dealt with the constitutionality of another MICRA modification, the collateral source rule. *See* CAL. CIV. CODE § 3333.1(a) (West Supp. 1986).

73. *Fein*, 695 P.2d at 679; *Roa*, 695 P.2d at 166; *Barme*, 689 P.2d at 448; *American Bank*, 683 P.2d at 675.

74. *American Bank*, 683 P.2d at 680.

75. *Roa*, 695 P.2d at 172.

76. *Id.* at 167 n.5.

77. All were four to three decisions except *Barme* (5-2).

78. *See, e.g.*, American Bank & Trust Co. v. Community Hosp., 683 P.2d 670 (Cal. 1984) (en banc) (majority and dissent disagreed about the constitutionality of the statute, but nevertheless did agree that rational basis test was appropriate standard of review). *See also* Hoffman v. United States, 767 F.2d 1431, 1436 (9th Cir. 1985) (federal equal protection challenge to MICRA damage cap; rational basis test appropriate barring the finding of a suspect class). *But see* Roa v. Lodi Medical Group, 695 P.2d 165, 172-86 (Cal. 1985) (Bird, C.J., dissenting). In her dissent, Chief Justice Bird *suggested* that the strict scrutiny standard should be utilized because she was of the opinion that the contingency fee sliding scale violated the right to petition the government for the redress of grievances, which is protected by the first amendment. She found it unnecessary to decide this issue, however, since she decided that the statutory provision could not withstand even the much less strict rational basis standard. *Id.* at 183.

79. *Fein*, 695 P.2d at 694-95 (Mosk, J., dissenting).

80. American Bank & Trust Co. v. Community Hosp., 683 P.2d 670 (Cal. 1984) (en banc).

81. *Id.* at 679 (footnote omitted).

the majority's approach as reducing "the rational relationship test to a rubber stamp."[82] Believing that the MICRA provision at issue in *American Bank* "burdens an overinclusive class of tort victims and benefits an overinclusive class of tortfeasors,"[83] she concluded that "[t]his is not the 'substantial and rational' relation between classification and legislative purpose that is required under the equal protection guarantee of the California Constitution."[84] Indeed, Chief Justice Bird characterized the majority's version of the rational relationship test as

> [precluding] any consideration of the actual impact of the challenged legislation. It ignores both the character of the burdened class and the nature of the interest at stake.
>
> . . . .
>
> . . . To invalidate discriminatory legislation under the majority's version of the rational relationship test, this court would have to conclude that the Legislature acted "irrationally" in passing it.[85]

For Justice Mosk, the other persistent dissenting voice, the route to determining a violation of the equal protection principle was somewhat different. The majority in *American Bank* had asserted that "the constitutionality of a measure under the equal protection clause does not depend on a court's assessment of the empirical success or failure of the measure's provisions."[86] For Justice Mosk, however, such an analysis was vital:

> The assumption that there exists a significant relationship between the reduction in malpractice premiums and a meaningful containment of medical costs to the general public lies at the heart of MICRA. Yet, a comparison between the amount of such premiums and the cost of hospital care in the years following the enactment of the legislation demonstrates that this premise is erroneous.[87]

In conclusion, it seems that the "Californian Quartet" has not only upheld one of the most comprehensive pieces of second generation crisis legislation, but has confirmed a growing judicial receptiveness to nearly all legislative attempts to mitigate the medical malpractice crisis. If the "Steelworkers Trilogy"[88] heralded a new era of judicial deference to

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82. *Id.* at 696 (Bird, C.J., dissenting).

83. *Id.* at 699.

84. *Id.*

85. *Id.* at 696. *See also* Logan v. Zimmerman Brush Co., 455 U.S. 422, 442 (1982) (Blackmun, J., concurring) ("The State's rationale must be something more than the exercise of a strained imagination; while the connection between means and ends need not be precise, it, at the least, must have some objective basis.")

86. *American Bank*, 683 P.2d at 679.

87. *Id.* at 685.

88. United Steelworkers v. Enterprise Wheel & Car Corp., 363 U.S. 593 (1960); United Steelworkers v. American Mfg. Co., 363 U.S. 564 (1960); United Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574 (1960).

the arbitration of industrial relations, this California Quartet similarly represents the current judicial disinterest in the future of malpractice regulation.

III. ARBITRATION AND MEDICAL MALPRACTICE CLAIMS

In the world of alternative dispute resolution as applied to medical malpractice claims, the term "arbitration" is somewhat chameleonic, maybe even Janus-faced. The use (or misuse) of the label "arbitration," however, is not the product of neglect.[89] Rather, it is an attempt to clothe a subject-specific dispute resolution system with the respectability long enjoyed by commercial and labor arbitration.

In the context of the malpractice crises, the term "arbitration" has been used to describe various dispute resolution mechanisms.[90] For the purposes of this Article, however, it will connote either a voluntarily executed contractual agreement to submit discovered malpractice claims to arbitration, in which the award is final,[91] or a similar agreement covering undiscovered as well as discovered claims.[92] These types of agreements alone comply with the classical tenets of arbitration as being both voluntary in its inception and binding in its award.[93] They

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89. *Cf.* REPORT, *supra* note 2, at 91-92 (Commission's findings that most people believe arbitration to be an effective settlement tool for malpractice cases).

90. Arbitration mechanisms may be conceptualized as follows:

Type A: An "arbitration" panel having mandatory exclusive and original jurisdiction over malpractice claims. The award of the panel is final. *See* P.R. LAWS ANN. tit. 26, §§ 4110, 4113(6) (Supp. 1984).

Type B: An "arbitration" (or "pretrial" or "professional liability review" or "malpractice review" or "mediation") panel having exclusive original jurisdiction over malpractice claims. Upon appeal by either party, a trial *de novo* is held, at which the finding(s) of the panel may or may not be admitted into evidence, with or without a modified burden of proof and with or without a costs penalty in the event that the panel's findings are confirmed. *See, e.g.*, MD. CTS. & JUD. PROC. CODE ANN. §§ 3-2A-01 to -09 (1984 & Supp. 1985); PA. STAT. ANN. tit. 40, §§ 1301.101 to .606 (Purdon Supp. 1985) (declared unconstitutional).

Type C: The same as *Type B*, except that submission of the claim to the panel is voluntary.

Type D: Judicially mandated "arbitration" of malpractice claims on a case-by-case basis. The award may or may not be final. *See, e.g.*, Broderick, *Compulsory Arbitration: One Better Way*, 69 A.B.A. J. 64 (1983). *See also* MINN. STAT. ANN. § 484.73 (West Supp. 1985) (not a malpractice-specific statute, but rather, a general judicial alternative dispute resolution system); WASH. REV. CODE ANN. §§ 7.06.010, .020 (Supp. 1985); G. WILNER, *supra* note 1, § 1.03.

Type E: A voluntarily executed contractual agreement to submit discovered malpractice claims to arbitration. The award is final.

Type F: The same as *Type E*, except that the agreement covers undiscovered as well as discovered claims.

91. This is a *Type E* arbitration mechanism. *See supra* note 90.

92. This is a *Type F* arbitration mechanism. *See supra* note 90.

93. "Arbitration" has been defined as follows:

also function as a conclusive substitute for litigation, rather than as an additional component of the traditional litigation process.[94]

Arbitration and pretrial review of medical malpractice claims serve different legislative goals. At the most general level, both are designed to freeze or slow the acceleration of the size of malpractice insurance premiums. The effect of pretrial review, however, is to chill plaintiff interest in pursuing marginal claims,[95] both practically and psychologically, and to encourage settlement by forcing additional plaintiff expenditure without providing for concomitant recovery. Arbitration, on the other hand, is viewed primarily as a constitutionally safe method of avoiding jury determinations of liability and quantum of damages. At a lower normative (interpretative) level of scrutiny, whereas mandatory pretrial review might be thought subject to restrictive judicial interpretation, this is in stark contrast to the oft-cited judicial enthusiasm for voluntary arbitration, coupled with judicial hesitancy to interfere with the arbitrators' views of the scope of an arbitration agreement.

There are two distinct juridical bases[96] for the execution and enforcement of medical malpractice arbitration agreements. These agree-

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> A process for the decision of conflicts by persons other than governmental judicial officers. The process leads to a decision by the "arbitrators" which is binding upon the parties, and this distinguishes it from *mediation* or *conciliation* where the role of the third parties is to bring the contending parties to settle their disagreement themselves.
>
> Arbitration is always voluntary, in the sense that no one can, as he can in a judicial law suit, be forced either to take part or lose the dispute. But a commitment to arbitration, of either a then existing dispute, or some or all disputes to arise in the future, and whether made by special agreement or pursuant to an "arbitration" clause in a contract, will ordinarily be enforced, *i.e.*, a court will order a party who has so agreed to go to arbitration, and bar him from a judicial determination.

Leff, *The Leff Dictionary of Law: A Fragment*, 94 YALE L.J. 1855, 2051-52 (1985) (emphasis in original). *See also* BLACK'S LAW DICTIONARY 96 (5th ed. 1979) ("The reference of a dispute to an impartial (third) person chosen by the parties to the dispute who agree in advance to abide by the arbitrator's award issued after a hearing at which both parties have an opportunity to be heard."); G. WILNER, *supra* note 1, § 1.01 ("It is axiomatic that commercial arbitration is based on a voluntary agreement of the parties; only then can the concept of arbitration be well understood.").

94. "Opportunity for de novo trial is what principally distinguishes court-annexed arbitration . . . from private arbitration conducted pursuant to the agreement of the parties . . . . The very essence of the term 'arbitration' in the latter context connotes a binding award." Blanton v. Womancare Inc., 696 P.2d 645, 648 (Cal. 1985) (en banc) (citations omitted). *See also* Comment, *The Constitutionality of Medical Malpractice Mediation Panels: A Maryland Perspective*, 9 U. BALT. L. REV. 75, 78 (1979).

95. Claims are adjudged marginal either because of the low quantum claimed, or the low probability of success at trial, or both.

96. A third basis is arbitration at common law. Absence of judicial enforcement prior to the award, however, makes it essentially irrelevant in the malpractice context. *See generally* G. WILNER, *supra* note 1, § 3.02.

ments will be made either under general state arbitration statutes,[97] which are themselves often total or partial adoptions of the Uniform Arbitration Act of 1955,[98] or under a specific medical malpractice arbitration statute.[99] Typically such a statute will define the parties who may execute a malpractice arbitration agreement and its subject matter applicability and will regulate certain substantive provisions in the agreement and the style and content of preexecution disclosure. Some statutes go so far as to dictate the selection process for the arbitrators and some aspects of the arbitration procedure itself.

There are three basic reasons for enacting specific malpractice arbitration legislation. First, it permits some or all aspects of the arbitration process to be tailored to suit the special nature of the medical claim.[100] Second, it offers the opportunity to provide for a certain degree of consumer protection-type regulation, both prior to[101] and following execution of the agreement to arbitrate.[102] Third, and most important, a state's enactment of such a statute will affect the question of whether a medical malpractice claim is arbitrable in that state.[103]

It does not necessarily follow, however, that the issue of arbitrability will remain open in those states that do not enact specific leg-

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97. *Id.* §§ 4.01–.02.

98. Unif. Arbitration Act, 7 U.L.A. 1 (1978 & Supp. 1985). *See generally The Uniform Arbitration Act,* 48 MO. L. REV. 137 (1983). For a nonuniform state's general arbitration statute, see Feldman, *Arbitration Modernized—The New California Arbitration Act,* 34 S. CAL. L. REV. 413 (1961). For a state-by-state breakdown of arbitration statutes and their potential for utilization in the malpractice context, see Wadlington, *Alternatives to Litigation IV: The Law of Arbitration in the U.S.*, in REPORT, *supra* note 2, at 346, 350-423 app.

99. As of 1985, 11 states had enacted specific malpractice arbitration statutes. ALA. CODE § 6-5-485 (1977); ALASKA STAT. § 09-55-535 (1983); CAL. CIV. PRO. CODE § 1295 (West 1982); GA. CODE ANN. §§ 9-9-11, -112 (1981); Health Care Arbitration Act §§ 1–14, ILL. ANN. STAT. ch. 10, §§ 201–214 (Smith-Hurd Supp. 1985); LA. REV. STAT. ANN. §§ 9:4230–:4236 (West 1983); MICH. COMP. LAWS § 600.5040–.5065 (1975); OHIO REV. CODE ANN. §§ 2711.21 –.26 (Baldwin 1984); S.D. CODIFIED LAWS ANN. §§ 21-25B-1 to -26 (1979 & Supp. 1984); VT. STAT. ANN. tit. 12, § 7001–7008 (Supp. 1985); VA. CODE § 8.01-581.1 to -581.12:2 (1984). *See generally* Ladimer, *Medical Malpractice Claims*, in ARBITRATION 301 (A. Widiss ed. 1979). The oft-cited Maine, ME. REV. STATS. ANN. tit. 24, § 2701-2715 (1977), and North Dakota, N.D. CENT. CODE § 32-29.1 (Supp. 1983), malpractice arbitration statutes have been repealed. For a proposed model act, see Note, *Medical Malpractice Arbitration: Time for a Model Act,* 33 RUTGERS L. REV. 454, 495-501 (1981). *See also* 9A AM. JUR. 2D LEGAL FORMS *Hospitals & Asylums* § 136.103 (1985) (model arbitration agreement).

100. For example, it might be specified that one of the arbitrators should be a health care provider.

101. *See infra* text accompanying notes 174-206. Note, however, that some general arbitration statutes do provide a modicum of consumer protection disclosure. *See, e.g.*, MO. REV. STAT. § 435.460 (Supp. 1984).

102. *See infra* text accompanying notes 214-41.

103. For the various meanings of "arbitrability," see *infra* text accompanying notes 110-12.

islation. For example, some general arbitration statutes specifically exclude agreements to arbitrate tort or personal injury claims.[104] Other statutes permit only the submission of postclaim (existing controversy) agreements,[105] and still others mandate a preexecution disclosure model that would make the formation of a malpractice arbitration agreement unlikely.[106]

Of those states that have enacted specific malpractice arbitration statutes, Alabama,[107] Georgia,[108] and Vermont[109] stand out in permitting the arbitration of existing medical malpractice disputes, while prohibiting agreements to resolve future disputes through arbitration.

IV. LEGAL PROBLEMS WITH MEDICAL MALPRACTICE ARBITRATION —AN ANALYTICAL MODEL

When a court is petitioned to compel or to stay arbitration in a malpractice case, a multitude of different legal issues may have to be resolved. An analytical model, illustrated hypothetically, may aid in comprehending the maze that lies ahead.

Suppose that Plaintiff (*P*) is admitted to Hospital (*D*) for medical treatment and that *P* executes an agreement with *D*, which provides that all claims which she might have relating to her care will be submitted to arbitration. Suppose further that a problem of some type arises, and *P* files a malpractice suit naming *D* as a defendant. *D*, relying on the terms of their agreement, files a motion to compel arbitration. *P* wishing to litigate her claim, files a motion to stay arbitration.

Our first problem is whether this general type of medical controversy is susceptible to arbitration at all. In other words, at an abstract (i.e., not fact-sensitive) level, is this general type of factual pattern amenable to resolution through arbitration?[110] Only in those jurisdic-

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104. *E.g.*, ARK. STAT. ANN. § 34-511 (Supp. 1985); KAN. STAT. ANN. § 5-401 (1982); S.C. CODE ANN. § 15-48-10(b)(4) (Law. Co-op. Supp. 1985). *See also* S.C. CODE ANN. § 15-48-10(b)(3) (Law. Co-op. Supp. 1985) (specific prohibition against "lawyer-client" or "doctor-patient" agreements).

105. *See, e.g.*, MO. REV. STAT. § 435.350 (Supp. 1984). Note also that Missouri excludes "contracts of insurance and contracts of adhesion." *Id.*

106. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 224 (c) (Vernon Supp. 1986).

107. ALA. CODE § 6-5-485(a) (1975).

108. GA. CODE ANN. 9-9-112 (1982).

109. VT. STAT. ANN. tit. 12, § 7002(a) (Supp. 1985).

110. As one court has described the issue, "[a]doption of an affirmative policy toward enforcement of arbitration agreements has never implied, however, that all types of disputes are subject to arbitration." Keating v. Superior Court, 645 P.2d 1192, 1202 (Cal. 1982), *rev'd on other grounds*, 465 U.S. 1 (1984).

For the tort or malpractice lawyer, this first arbitrability issue may be seen as somewhat analogous to the "duty of care" issue. In other words, the tort question—does this general type of allegation of blameworthy conduct invite judicial resolution (or regulation)?—becomes the arbitrability question—do we, the judicial regula-

tions that have specific malpractice arbitration statutes is this "arbitrability as a matter of law" issue quickly resolved. Yet even in those jurisdictions, this general or first level arbitrability issue is not so much resolved as it is replaced with a second level of inquiry. This second level is a *fact-sensitive* investigation into whether the agreement in question falls within the terms of the jurisdiction's malpractice arbitration facilitating legislation.

There is a complex interrelationship between these two levels of inquiry. In the first place, if our judge determines that the agreement at issue does not fall within the terms of the facilitating legislation, the issue of arbitrability returns to the first level for determination. Second, even in jurisdictions where there is a malpractice arbitration statute, our judge may succumb to temptation and make an initial subconscious (or "off-camera") determination about the general appropriateness of malpractice arbitration. This will then color her view of the reach or scope of the statute—explicitly, the second level of inquiry. Even if our judge finds that the hypothetical circumstances described above are arbitrable as a matter of law, or that the statute involved covers this general type of claim, a final issue or third level of inquiry into arbitrability remains. The judge (or, more frequently, the arbitrator) must examine the peculiar circumstances of the case to determine whether the claim falls within the ambit of the agreement to arbitrate. At a *fact-intensive*, contractual interpretative level, is this particular *controversy* covered by this particular agreement to arbitrate?[111] It is important to note that the three arbitration levels are conceptually divisible into three ascending levels of factual specificity. Only when the answers to the inquiries generated by each succeeding level are positive is the agreement to arbitrate enforceable.[112]

Unfortunately for our judge in the above hypothetical, however, her inquiry must continue. Not only must the agreement be "arbitrable," but it must be "valid." This validity determination, like that of

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tors, object to this general type of allegation being resolved in a nonjudicial forum? *See generally* Henderson, *supra* note 2, at 971-76.

111. *Cf.* G. WILNER, *supra* note 1, § 13.08. Wilner does not distinguish between the different types or levels of arbitrability. Note that the different levels of arbitrability identified do *not* correspond to the substantive/procedural arbitrability distinction sometimes drawn. *See, e.g.*, F. ELKOURI & E. ELKOURI, *supra* note 1, at 215-16.

112. Two further points should be noted. First, some malpractice arbitration issues, but *not* the issue of arbitrability, have come before the courts in jurisdictions that do not (or did not then) have specific malpractice arbitration statutes. *See, e.g.*, Doyle v. Giuliucci, 401 P.2d 1 (Cal. 1965) (en banc); Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775 (Ct. App. 1976); Zupan v. Firestone, 457 N.Y.S.2d 43 (App. Div. 1982), *aff'd*, 450 N.E.2d 245 (N.Y. 1983).

Second, because of the general judicial policy favoring arbitration, the third fact-intensive level of arbitrability will often be left to the arbitrator alone to decide. *See generally* Henderson, *supra* note 2, at 971-76.

arbitrability, is characterized by three specificity levels.

At the first level of the validity inquiry, a judge must evaluate the general constitutionality of the statute facilitating arbitration. The judge must consider possible violations of due process, equal protection, and the right to a jury trial before concluding for or against general validity.

The second level is more fact-sensitive and focuses primarily on the terms of the agreement. For example, if *P* were compelled to sign a preclaim arbitration agreement as a condition to treatment by *D*, then a substantive conscionability question would arise.

Similarly, but even more factually focused, are procedural conscionability issues. If the actual preexecution disclosure of the agreement's nature or effect was insufficient to give full understanding (for example, if *P* signed without explaining her surrender of the right to jury trial), then the judge might properly grant the motion to stay arbitration.

As between *P* and *D*, then, validity, like arbitrability, will depend on a multiplicity of gradated, specific determinations of fact and policy.[113] These evaluations, however, must not be allowed to converge. It is vital that traditional tenets of arbitration law, such as judicial deference to the arbitrator's views on the scope of the agreement to arbitrate, should not be allowed to bleed off into the distinct public policy-based inquiries that are clearly and appropriately within the realm of judicial scrutiny.

V. General Arbitrability as a Matter of Law

It is arguable whether arbitration is appropriate in the malpractice context at all. In the first place, arbitration classically is applied to claims or controversies arising out of a contract that includes an arbitration clause. Yet, while it is correct that the patient-provider relation-

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113. The review model used here is illustrated by the following schematic:

	Decisional Issue	
	A. *Arbitrability*	B. *Validity*
Type of Judicial Scrutiny		
1. Abstract	Arbitrability as a Matter of Law	Constitutionality of Facilitating Statute
2. Fact-Sensitive	Scope of Facilitating Statute	Substantive Conscionability of Agreement to Arbitrate
3. Fact-Intensive	Scope of Agreement to Arbitrate	Procedural Conscionability of Agreement to Arbitrate

ship may be grounded in contract, the contract is not the sole source of the duties imposed upon providers by the courts. If it were, the courts would hardly have objected to contractual modifications of those duties.[114] Rather, responsibility for the regulation of the quality of medical care has been allocated to the torts system.

The distinction between contract law and tort law drawn here is not an idle, semantic one. Neither is this merely another skirmish in the contract versus torts territorial dispute. Instead, it is an issue that goes to the heart of the arbitration process and to the function of the arbitrator within that process. The arbitrator is a "contract reader."[115] He may be a highly competent and respected interpreter, but he is not a regulator.[116] The judge and jury in a malpractice case do not and should not speak *for* the parties in their contractual relationship.[117] They speak *about* that relationship, applying normative values and yes, even sentiments, distinct from it.[118]

Second, there are important consumer protection and accident cost avoidance reasons for refusing to allow malpractice litigation to be supplanted by arbitration.[119] For the protection of consumers, arbitration should be permitted only when there has been regulation of the mode

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114. *See generally* Annot., 6 A.L.R.3d 704 (1966).

115. *See* St. Antoine, *Judicial Review of Labor Arbitration Awards: A Second Look at* Enterprise Wheel *and Its Progeny*, in ARBITRATION—1977, PROCEEDINGS OF THE THIRTIETH ANNUAL MEETING, NAT'L ACAD. OF ARBITRATORS 29, 30 (B. Dennis & G. Somers eds. 1978).

> [Members of the Academy] fall into two distinct groups: (a) those who, with refreshing modesty, call themselves *simple contract readers*, and (b) those, somewhat less modest, who are prepared to go beyond the contract and to read and interpret laws, statutes, regulations, and anything else (including Playboy, Playgirl, Penthouse and Hustler) that the parties, in their infinite wisdom, think pertinent to the issues.

Id. at 30. *Cf.* Gold, *Small Claims Grievance Arbitration*, in ARBITRATION—1983, PROCEEDINGS OF THE THIRTY-SIXTH ANNUAL MEETING, NAT'L ACAD. OF ARBITRATORS 16, 17-18 (J. Stern & B. Dennis eds. 1984). *See also* Dunsford, *The Role and Function of the Labor Arbitrator*, 30 ST. LOUIS U.L.J. 109 (1985).

116. Consider, for example, the issues arising when arbitration of allegations of discrimination is contemplated. *See* Edwards, *Arbitration of Employment Discrimination Cases: An Empirical Study*, in ARBITRATION—1975, PROCEEDINGS OF THE TWENTY-EIGHTH ANNUAL MEETING, NAT'L ACAD. OF ARBITRATORS 59, 70-81 (B. Dennis & G. Somers, eds. 1976). *See also* Oppenheimer & LaVan, *Arbitration Awards in Discrimination Disputes: An Empirical Analysis*, 34 ARBITRATION J. 12 (1979).

117. Compare the role of the arbitrator: "So long as he is dealing with a matter duly submitted to him, the arbitrator is speaking for the parties, and his award *is* their contract." St. Antoine, *supra* note 115, at 35 (emphasis in original).

118. For similar issues arising in the context of child custody, see Faherty v. Faherty, 477 A.2d 1257 (N.J. 1984); Fence v. Fence, 314 N.Y.S.2d 1016, 1019-20 (Fam. Ct. 1970).

119. *Cf.* Henderson, *supra* note 2, at 956 ("No doctrine of public policy or rule of law precludes the use of arbitration in the area of medical services.").

and content of the provider's disclosure of the nature and impact of arbitration.[120] With regard to accident avoidance,[121] there are important public interests involved in the regulation of the health care industry that should militate against the totally private resolution of claims.[122] Not only does the litigation system have an important deterrence function,[123] but deserving claimants forced to arbitrate may find themselves at a disadvantage because arbitration proceedings often lack the usual pretrial tools available to assist plaintiffs in the making of their cases.[124]

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120. O'Keefe v. South Shore Internal Medicine Assocs., 422 N.Y.S.2d 828, 832 (Sup. Ct. 1979).

121. *See generally* G. CALABRESI, THE COST OF ACCIDENTS (1970).

122. *See, e.g.*, Tatham v. Hoke, 469 F. Supp. 914, 918-19 (W.D. N.C. 1979). *Cf.* Note, *supra* note 99, at 491-93 (stating that "public policy would tend to support arbitration as an alternative to litigation") (footnote omitted). *See also* City of Boston v. Boston Patrolmen's Ass'n, 392 N.E.2d 1202 (Mass. App. Ct. 1979) (advocating balancing test between policy issues and subject of arbitration); Baker v. Townsend, 129 Eng. Rep. 169 (1817).

An analogy can be drawn to the arbitration of securities disputes. *See, e.g.* Wilko v. Swan, 346 U.S. 427 (1953). If the initial premise is accepted that the regulation of the quality of medical care is of a similar order of societal and economic importance as the regulation of the securities market, then the Court's opinion in *Wilko*, a case dealing with the arbitrability of a securities dispute, could perhaps be modified as follows:

> Two policies, not easily reconcilable, are involved in this case. [The states have] afforded participants in [health care] transactions subject to [their] legislative power an opportunity generally to secure prompt, economical and adequate solution of controversies through arbitration if the parties are willing to accept less certainty of legally correct adjustment. On the other hand, [states have developed malpractice law] to protect the rights of [patients] and [have] forbidden a waiver of any of those rights. [*See, e.g.*, Annot., 6 A.L.R. 3d 704 (1966)]. Recognizing the advantages that prior agreements for arbitration may provide for the solution of commercial controversies, we decide that the intention of [the states] concerning the [provision of medical services] is better carried out by holding invalid such an agreement for arbitration of issues arising [in the malpractice context.]

Id. at 438 (footnote omitted). *Cf.* Dean Witter Reynolds Inc. v. Byrd, 105 S. Ct. 1238 (1985) (White, J., concurring); Sacks v. Dean Witter Reynolds Inc., 627 F. Supp. 377 (C.D. Cal. 1985).

123.

> After considering both knowns and unknowns of the law of medical malpractice, we believe the tort approach provides a significant, and necessary, deterrent against incompetent and careless rendition of medical services. It also confers intangible benefits, for example in citizen perceptions of the justice of imposing liability on those culpably responsible for injuries. If the tort system offers these benefits imperfectly, we find no evidence that alternative general approaches would be superior either in producing cost-effective medical care or in generating just results.

TOWARDS A JURISPRUDENCE OF INJURY: THE CONTINUING CREATION OF A SYSTEM OF SUBSTANTIVE JUSTICE IN AMERICAN TORT LAW, REPORT TO THE AMERICAN BAR ASSOCIATION 11-32 (1984).

124. *See, e.g.*, O'Keefe v. South Shore Internal Medicine Assocs., 422 N.Y.S.2d

Finally, compelling the submission of a malpractice claim to arbitration may have the effect of increasing the length and expense of resolving malpractice disputes. It is extremely unlikely, given the complexity of modern medicine and the reach of modern malpractice law, that all the potential plaintiffs and defendants will have been parties to the arbitration agreement. Inefficient multiple proceedings seem inevitable.[125]

VI. CONSTITUTIONALITY OF VOLUNTARY ARBITRATION STATUTES

To make a successful constitutional challenge to a statute facilitating or regulating arbitration is notoriously difficult.[126] At the root of the problem is the "voluntary" nature of the arbitration agreement. Statutorily facilitated elective agreements are not amenable to "access to the courts" or "trial by jury" challenges under state constitutions.[127] Moreover, judicial acceptance of the theoretically voluntary nature of such[128] agreements makes facilitating legislation virtually immune from equal protection challenge.

In *Dickinson v. Kaiser Foundation Hospitals*,[129] the plaintiff argued for the correction of an arbitration award otherwise in his favor because the arbitrator had not awarded him costs. Specifically, he challenged the constitutionality of a California statute that provided, "[u]nless the arbitration agreement otherwise provides or the parties to the agreement otherwise agree, each party to the agreement shall pay his pro rata share of the expenses and fees . . . ."[130] The court opined that

> [t]here is no denial of equal protection since the parties provided for arbitration by their own agreement, in order to gain the benefits of

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828, 831 (Sup. Ct. 1979). ("[T]he appellate courts have noted that the plaintiff in a medical malpractice action is most often less likely than the defendant to have knowledge of proper surgical techniques or procedures, medicines and tests.") (citation omitted).

125. *Id.*

126. *See* G. WILNER, *supra* note 1, § 4.02. *See generally* Adams & Bell, *Alternatives to Litigation, II: Constitutionality of Arbitration Statutes*, in REPORT, *supra* note 2, at 315 app. (dealing with compulsory arbitration models).

127. *See, e.g.*, State *ex rel.* Cardinal Glennon Memorial Hosp. v. Gaertner, 583 S.W.2d 107, 111 (1979) (Simeone, J., concurring). *See also* Opinion of the Justices, 304 A.2d 881, 887 (N.H. 1973) ("[I]t is clear from the language . . . of the . . . [state] constitution that neither the legislature nor the courts, by rules or otherwise, have the right or power to deny the parties a jury trial *without consent* . . . .") (emphasis added).

128. Consider whether the Alaskan arbitration statute is truly voluntary. If the parties do *not* agree to arbitrate a claim under ALASKA STAT. § 09-55-535 (1983), *compulsory* pretrial "advisory panel" review under § 09-55-536 is triggered.

129. 169 Cal. Rptr. 493 (Ct. App. 1980).

130. CAL. CIV. PRO. CODE § 1284.2 (West 1982).

> the simplified arbitration process and avoid the disadvantages of court litigation. The parties could reach their own agreement as to how the costs of arbitration should be awarded. The Constitution does not require that costs be awarded in the same manner as in judicial proceedings.[131]

Thus, unequal treatment of the arbitrating medical malpractice claimant as compared to the litigating claimant may be rationalized (or transparently characterized) as the product of provider-claimant pre-agreement negotiation, rather than statutory discrimination. A plaintiff's challenge will not survive long enough to attract even limited rational basis review.[132] It seems likely that the courts are unwilling to examine the arguably *involuntary* nature of malpractice arbitration agreements at the level of constitutional review because there are lower order normative constructs such as conscionability that are available to achieve or approximate consensual agreement.

Unless the plaintiff can establish the constitutional invalidity of the facilitating statute, however, she will be unable to argue that the claim is nonarbitrable as a matter of law. In the absence of a frontal attack on the *principle* of such state facilitation, three alternative approaches suggest themselves. First, although a state arbitration statute is not unconstitutional in permitting arbitration, it may be challengeable with regard to the detailed arbitration issues it mandates. Second, the facilitating statute may be defective because it is unconstitutionally vague. Finally, the statute may be invalid in practice, rather than in principle.

The first of these approaches was dealt a possibly fatal blow by the Supreme Court of Michigan in *Morris v. Metriyakool*.[133] The Michigan medical malpractice arbitration statute, while specifying that execution of the arbitration agreement was to be voluntary, nevertheless mandated the composition of the arbitration panel.[134] Specifically, the

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131. *Dickinson*, 169 Cal. Rptr. at 494 (citations omitted).

132. *See supra* text accompanying notes 57-87. *See also* Eastin v. Broomfield, 570 P.2d 744, 751 (Ariz. 1977) (en banc) (Arizona's mandatory pretrial "arbitration" panel survived equal protection review); *In re* LiVolsi, 428 A.2d 1268 (N.J. 1981) (compulsory arbitration of attorney-client fee disputes survived rational relationship standard of equal protection review); Beatty v. Akron City Hosp., 424 N.E.2d 586 (Ohio 1981) (state had rational basis for statute establishing an arbitration board and proceedings).

133. 344 N.W.2d 736 (Mich. 1984). For the constitutionality issue as considered by Michigan's intermediate appellate courts, see Findlater & Ettelbrick, *Contracts*, 30 WAYNE L. REV. 421, 442-44 (1984).

134. MICH. COMP. LAWS ANN. §§ 600.5041(1)–.5042(1) (West 1975). Statutes that provide for voluntary arbitration but that mandate the composition of the arbitration panel are not uncommon. See ALA. CODE § 6-5-485(b) (1975); ALASKA STAT. § 09.55.535(f) (1983); GA. CODE ANN. § 9-9-117 (1982); Health Care Arbitration Act § 13, ILL. ANN. STAT. ch. 10, § 213 (Smith-Hurd Supp. 1985); OHIO REV. CODE ANN.

statute provided for a panel composed of an attorney, a physician or hospital administrator, and a third member who was neither.[135] The plaintiffs argued that their procedural due process rights were infringed by the probability of bias on the part of the medical provider panel member.[136] For the majority there was insufficient evidence of bias:

> [I]t has not been demonstrated that the medical members of these panels have a direct pecuniary interest or that their decision may have any substantial effect on the availability of insurance or insurance premiums. We have been shown no grounds sufficient for us to conclude that these decisionmakers will not act with honesty and integrity. We look for a pecuniary interest which creates a probability of unfairness, a risk of actual bias which is too high to be constitutionally tolerable. It has not been shown here.
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> . . . .
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> We do not believe that the medical members of these panels are so identified and aligned with respondents in malpractice cases that they may be expected to favor the respondents. Physicians and other health professionals are trained in the medical arts and are oath-bound to treat the ill. Hospital administrators are trained in the proper functioning of hospitals. Neither physicians nor hospital administrators have professional interests that are adverse to patients or even malpractice claimants on a consistent, daily basis. Any identity of interest with respondents is not so strong as to create a subliminal bias for one side and against the other.[137]

Presume, however, that the due process challenge to such a statutory provision had been accompanied by sufficient evidence of the risk of bias. The result reached in *Morris v. Metriyakool* would probably be unaffected. The presumed voluntary nature of malpractice arbitration would deflate the constitutional challenge here because due process review presupposes "state action." According to the concurring opinion of Justice Ryan, however, the state establishment and regulation of

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§§ 2711.21(A)–.23(F) (Baldwin 1984); S.D. CODIFIED LAWS ANN. §§ 21-25B-4, -10 to -11, -13 to -15 (1979 & Supp. 1984); VT. STAT. ANN. tit. 12, §§ 7001–7002(a),(c) (Supp. 1985).

135. MICH. COMP. LAWS ANN. § 600.5044(2) (West Supp. 1980).

136. Specifically, the concern involved the adjudicator's interest in the cost of malpractice insurance. *See Morris*, 344 N.W.2d at 737. *See generally* Bedikian, *supra* note 9, at 294-97; Mengel, *The Constitutional and Contractual Challenges to Michigan's Medical Malpractice Arbitration Act*, 59 J. URB. L. 319, 331-35 (1982); Note, *The Michigan Malpractice Act's Requirement of a Physician on the Panel Violates the Due Process Right to a Fair and Impartial Tribunal*, 28 WAYNE L. REV. 1843 (1982).

137. *Morris*, 344 N.W.2d at 740-71. Compare that view with Justice Cavanagh's dissent: "[The] situation thus presents too high a risk of actual bias on the part of the medical-member decisionmakers to be constitutionally permissible." *Id.* at 761 (Cavanagh, J., dissenting) (footnote omitted). *See also* Vincent v. Romagosa, 425 So. 2d 1237 (La. 1983) (upholding medical review panel against challenge of partiality).

malpractice arbitration do not constitute such state action:

> Here, the State of Michigan has not compelled the parties to arbitrate their disputes concerning medical malpractice, but has merely announced the circumstances under which its courts will not interfere with a private agreement to arbitrate medical malpractice disputes. Indeed, the crux of plaintiffs' complaint is not that the state has acted, but that the state has refused to act to prohibit private agreements to arbitrate before a three-person panel, one of whom is a doctor or a hospital administrator. The statutory refusal to act is no different than an ordinary statute of limitations by which the state declines to provide a civil trial remedy for medical malpractice after the passage of a given period of time.[138]

Clearly, the importance of Justice Ryan's characterization of malpractice arbitration legislation is that it "cuts off at the pass" due process review. The challenger is prevented from developing any evidence of potential bias or other alleged defects[139] in the state's arbitration

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138. *Morris*, 344 N.W.2d at 753 (emphasis omitted). Again, contrast the Cavanagh dissent:

> [A]lthough there is no initial state action, *i.e.*, the parties are not compelled to execute an arbitration agreement, there is state action in the execution itself and after execution, *i.e.*, the state requires (1) certain terms to be included in the agreement, and (2) specific procedures pursuant to the agreement. Indeed, the enactment of a broad statutory scheme is an expression of the public policy of the state and, to this extent, certainly constitutes "encouragement" of arbitration agreements by the state.
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> . . . Although the state can acquiesce in one's choice of a dispute resolution mechanism, it cannot statutorily mandate procedures pursuant to the mechanism selected which abridge constitutional rights. Consequently, it should be concluded that, under federal constitutional law, these cases involve state action.

Id. at 762-63 (Cavanagh, J., dissenting).

The Supreme Court's view on "state action" may be gauged from Blum v. Yaretsky, 457 U.S. 991 (9182) (nursing home's receipt of Medicaid funding and state regulation of nursing home do not convert nursing home's treatment of patients into "state action"); Rendell-Baker v. Kohn, 457 U.S. 830 (1982) (privately operated school's receipt of state and federal funding did not render the school's personnel discharge decisions acts of the state); Lugar v. Edmondson Oil Co., 457 U.S. 822 (1982) (statutory scheme for attachment subject to procedural due process requirements and invoked by private party rendered that private party a "state actor").

Quaere has state facilitation of malpractice arbitration involved such significant encouragement to health care providers that the choice to arbitrate must be seen as the state's not merely the health care provider's? Does the replacement of malpractice litigation with arbitration involve the exercise of traditionally state powers by a private individual? *See Blum*, 457 U.S. at 1004-05.

139. An example of a defect would be the nonavailability of arbitrators to serve as the panel. *Cf.* Vincent v. Romagosa, 425 So. 2d 1237 (La. 1983) (upholding pretrial review panel in the face of a similar allegation).

facilitating legislation.[140] Equally clearly, judicial reluctance to deal with alleged general panel bias at the constitutional level must be explicable in part by the existence of another phase of judicial scrutiny (petition to set aside award) at which any particular arbitrator misconduct could be examined.[141]

The second type of challenge to arbitration statutes is based upon the argument that they are impermissibly vague, thereby affronting a claimant's reasonable expectations and hence his due process rights. In other words, an individual claimant's difficulties in interpreting both the scope of the facilitating statute and the scope of the arbitration agreement may be combined to raise the more general issue of constitutional validity.

Several difficulties may be encountered with this approach. Arbitration enabling statutes are not norm producing, but are merely forum directing.[142] Moreover, poor draftsmanship does not by itself constitute unconstitutional "vagueness."[143] Finally, malpractice statutes, while perhaps lacking clarity, do tend to use standard malpractice "terms of art." They should, therefore, be amenable to state supreme court interpretation, arguably lessening the need for their invalidation.

The third suggested approach to constitutional challenge of an arbitration statute depends upon how the arbitration system operates in practice in a given state. In 1978, the Supreme Court of Pennsylvania upheld the constitutionality of that state's mandatory pretrial arbitration system in the face of challenges asserting the right to trial by jury, the doctrine of separation of powers, and procedural due process.[144] In 1980, however, a challenger successfully attacked that same system in

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140. This explains the collateral skirmish between Justices Ryan and Cavanagh over the order in which the issues should be considered. *See Morris*, 344 N.W.2d at 747 n.2, 758 n.4.

141. *See* Good v. Kaiser Found. Hosps., 199 Cal. Rptr. 581 (Ct. App. 1984); Hartman v. Cooper, 474 A.2d 959 (Md. Ct. Spec. App. 1984); King v. Retz, 454 N.Y.S.2d 594 (Sup. Ct. 1982); Menardi v. Petrigalla, 462 N.E.2d 1246 (Ohio Ct. App. 1983). *See also* Dinong v. Superior Court, 174 Cal. Rptr. 590 (Ct. App. 1981) (disqualification of arbitrator on ground of impartiality not proper when arbitration agreement contained no requirement of impartiality, but rather gave unqualified right to party to nominate anyone as arbitrator).

Additionally, an unconscionability attack should not be ruled out in these arbitrator situations. *See* Graham v. Scissor-Tail, Inc., 623 P.2d 165, 176 (Cal. 1981) (en banc) ("[I]f a party resisting arbitration can show that the rules under which arbitration is to proceed will operate to deprive him of what we in other contexts have termed the common law right of fair procedure, the agreement to arbitrate should not be enforced.").

142. *See* Grayned v. City of Rockford, 408 U.S. 104, 108-09 (1972).

143. *Cf.* Jones v. City of Lubbock, 727 F.2d 364, 373 (5th Cir. 1984) (held that "a civil statute may require or proscribe conduct so vaguely that it violates due process").

144. Parker v. Children's Hosp., 394 A.2d 932 (Pa. 1978).

Mattos v. Thompson,[145] asserting that it violated the litigant's constitutional right to trial by jury. The court's acceptance of this new challenger's contentions was due primarily to the fact that by the time *Mattos* was argued there was significant objective evidence which suggested that the statutory system was totally incapable of keeping pace with the volume of malpractice litigation that had been instituted. This resulted in "oppressive delay and impermissibly infringe[d] upon the constitutional right to a jury."[146]

The successful use of this approach in the voluntary arbitration context would undoubtedly require the development of statistical evidence that, for example, the arbitration process was empirically incapable of dealing with submitted claims, or was clearly diminishing provider liability.[147] In addition, this approach would also require reconsideration of any prior judicial determination of the absence of "state action."

VII. UNCONSCIONABILITY AND ARBITRATION AGREEMENTS

For the purposes of analysis, and notwithstanding the differing judicial conclusory language involved, it is suggested that use of the terms "adhesion" and "unconscionability" connotes the following structured analysis. Presume that a court concludes that a provision in a proferred contract (e.g., waiver of trial by jury) or a circumstance in the negotiation phase (e.g., acceptance of the arbitration agreement as a prerequisite to the provision of medical services) or a refusal to negotiate (e.g., the compulsory use of a standardized form) is oppressive. Depending upon the court's view of the severity of that oppression, two judicial labels may be applied; the contract suffers from "substantive unconscionability" or is considered to be a "contract of adhension."[148] The use of the former term implies a judicial determination to void the contract, and further consideration of the contract's validity ceases because of the finding of substantive invalidity. Application of the latter label marks the starting point for additional levels of judicial scrutiny.

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145. 421 A.2d 190 (Pa. 1980).

146. *Id.* at 196. For a post-*Mattos* defense of the system, see Lewis, *Malpractice Arbitration: Is Pennsylvania's System Dead or Alive?*, LEGAL ASP. MED. PRAC., July 1981, at 1.

147. Of course, the inherent difficulties of obtaining empirical data must be measured against the *Mattos* standard, which calls for the utilization of such data without considering those problems. For an expression of this pragmatic view, see American Bank & Trust Co. v. Community Hosp., 683 P.2d 670, 684-87 (Cal. 1984) (en banc) (Mosk, J., dissenting). To this might be added the notion that, even if such data were collected, there will still be a fair probability of misinterpretation in whole or in part.

148. Obviously, matters are not quite as "neat" in practice. Thus, the "adhesion" characterization will be a criterion in a determination of substantive unconscionability, and allegations of the oppressive nature of the precontract scenario will plug into the "adhesion" determination.

First, under a procedural unconscionability analysis, one should inquire whether the terms and impact of the agreement have been sufficiently disclosed to the party in the weaker bargaining position. If they have been so disclosed, the inquiry then becomes whether the terms of the agreement should be interpreted to favor the person in the weaker bargaining position.[149]

At first glance, an agreement between a patient and a health care provider to submit malpractice claims to arbitration is a contract of adhesion[150] and possibly unconscionable.[151] Such labeling is premature, however, for it ignores the statutory foundation of the arbitration agreements considered herein.[152] A determination that an agreement comes within the scope of a malpractice aribitration statute encourages not only the conclusion that the claims arising are arbitrable as a matter of law, but also that the agreement is conscionable in substance. Indeed, the California arbitration statute *declares* such an agreement not to be unconscionable.[153]

Some statutes go further and expressly condition conscionability on the fulfillment of specific substantive and procedural criteria.[154] As a

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149. *See generally* Wright, *Arbitration Clauses in Adhesion Contracts*, 33 ARBITRATION J. 41 (1978). Clearly, these issues are for the court to address at the time it is considering the motions to stay or compel arbitration. *See also* Note, *Federal Preemption of Arbitration*, 1984 J. DISPUTE RESOLUTION 193:

> The defense of unconscionability of the underlying contract has been held to be an issue for the arbitrators. Similar issues arise with respect to the defense of illegality of the underlying contract. If the claim is unconscionability of the arbitration clause itself, the claim should be decided by the courts.

Id. at 202-03 (footnotes omitted).

150. *But see* CAL. CIV. PRO. CODE § 1295 (West 1982) (statutory compliance will per se negate any contractual adhesion). *Cf.* Victoria v. Superior Court, 222 Cal. Rptr. 1, 6 (Ct. App. 1985) (standard form contact proffered by provider exempt from § 1295 was not contract of adhesion, but did have "some adhesive characteristics").

151. For a very thorough analysis of unconscionability and its utility, see Leff, *Unconscionability and the Code—The Emperor's New Clause*, 115 U. PA. L. REV. 495 (1967); see also Ellinghaus, *In Defense of Unconscionability*, 78 YALE L.J. 757 (1969) (discussion of the Leff analysis).

152. As has been stated in one opinion,

> [a] finding of unconscionability generally reflects a determination that enforcement of a particular agreement is contrary to public policy. I agree that enforcement of these agreements is bad policy. Nevertheless, in the last analysis, determination of public policy is the province of the Legislature. Where the Legislature has unambiguously endorsed a particular kind of agreement, the judiciary is no longer free to declare that such agreements are unconscionable. It seems to me that the Legislature has, wrongly or rightly, given its unqualified seal of approval to these arbitration agreements, and that I must therefore defer to its declaration of public policy.

Strong v. Oakwood Hosp. Corp., 325 N.W.2d 435, 439 (Mich. Ct. App. 1982) (Maher, J., concurring).

153. CAL. CIV. PRO. CODE § 1295(e) (West 1982).

154. *See infra* text accompanying notes 164-206.

complication, not all such statutory provisions apply with equal force to both pretreatment and postclaim arbitration agreements. Furthermore, different considerations may apply to the analysis of the conscionability of agreements entered into as part of a group health plan in contrast to individual patient-provider agreements.

Unconscionability issues[155] furnish perhaps the finest illustration of how arbitration agreements and medical malpractice claims make uneasy bedfellows. Parties to commercial contracts and collective bargaining agreements genuinely want interpretative disputes to be arbitrated.[156] For them, the procedural speed and economy and adjudicatory expertise traditionally associated with arbitration hold a great attraction.[157] The parties generally are in agreement about the applicable substantive norms.[158] Within the context of their long-term relationships and the overall purpose of their contracts, they have little to lose and much to gain.[159] Indeed, today's employee grievance upheld will be tomorrow's grievance dismissed.[160] Yet for the medical malpractice claimant there is "no tomorrow," and she has much to lose.[161]

Of course, this thesis is disputable. According to the Supreme Court of California,

> [t]he speed and economy of arbitration, in contrast to the expense and delay of jury trial, could prove helpful to all parties; the simplified procedures and relaxed rules of evidence in arbitration may aid an injured plaintiff in presenting his case. Plaintiffs with less serious injuries, who cannot afford the high litigation expenses of court or

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155. *See generally* Bedikian, *supra* note 9, at 299-301; Henderson, *supra* note 2, at 985-97; Mengel, *supra* note 136, at 327-31; Note, *supra* note 11, at 144-50. *See also* Henderson, *Alternatives to Litigation III: Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice,* in REPORT, *supra* note 2, at 321 app. [hereinafter cited as Henderson, *Alternatives*].

156. *See generally* Mentschikoff, *supra* note 1, at 850-52.

157. *See* F. ELKOURI & E. ELKOURI, *supra* note 1, at 7-8 nn.31-32.

158. Mentschikoff, *supra* note 1, at 868. *See also* Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change,* 9 LAW & SOC'Y REV. 95, 130-32 (1974).

159. *See, e.g.,* United Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574, 578 (1960). *See also* F. ELKOURI & E. ELKOURI, *supra* note 1, at 1, 4-7.

160. "[T]he grievance procedure, including arbitration, is more than a method for resolution of individual disputes—it is an integral 'part of the continuous collective bargaining process.' " Kinyon & Rohlik, *"Deflouring" Lucas Through Labored Characterizations: Tort Actions of Unionized Employees,* 30 ST. LOUIS U.L.J. 1, 26 (1985) (quoting United Steelworkers v. Warrier & Gulf Navigation Co., 363 U.S. 574, 581 (1960)) (footnote omitted). *See also* St. Antoine, *supra* note 115, at 32. ("The arbitrator's award is not so much an interpretation of the collective bargaining agreement as an organic extension, a fulfillment, a flowering of the seed it planted.").

161. To put it slightly differently, the malpractice plaintiff is a "one-shotter." The parties to a collective bargaining agreement (and for that matter, the insurance companies that stand behind medical malpractice defendants) are "repeat players." *See* Galanter, *supra* note 158, at 97.

> jury trial, disproportionate to the amount of their claim, will benefit especially from the simplicity and economy of arbitration; that procedure could facilitate the adjudication of minor malpractice claims which cannot economically be resolved in a judicial forum.[162]

The use of a small claims example, rather than the paradigmatic malpractice case, clearly exposes this opinion as stemming from a judicial predisposition toward malpractice arbitration. Further, can the court's argument be refuted simply by referring to the number of challenges to submission (both to validity and arbitrability) brought by claimants as opposed to those brought by providers? Can it be attacked by pointing out the lengths to which some legislatures have gone in mandating both revocability rights and formal patient disclosure? Herein lie the greatest ironies. If the patient and the provider are equally interested in arbitration, why should such consumer protection be necessary? And if through such disclosure, either legislatively or judicially mandated, the consumer is provided with perfect information, may that not make it extremely unlikely that any arbitration agreements will be executed?

If the legislatures and courts permit providers to externalize some or all of the information costs associated with the agreement-forming process, can the system that remains truly be described as one of "voluntary" arbitration? The problem was well summarized by a California appellate court which concluded that "notwithstanding the cogency of the policy favoring arbitration and despite frequent judicial utterances that because of that policy every intendment must be indulged in favor of finding an agreement to arbitrate, the policy favoring arbitration cannot displace the necessity for a voluntary agreement to arbitrate."[163]

A. *Substantive Conscionability*

Once it is accepted that there is considerable provider interest in having malpractice claims arbitrated, the purely voluntary nature of arbitration becomes jeopardized. There will be no "voluntary" agreements when every provider in a given locale insists upon the inclusion of an arbitration clause in its contracts for care and treatment.[164] Such

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162. Madden v. Kaiser Found. Hosps., 131 Cal. Rptr. 882, 890 (1976). *Cf.* Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 786 (Ct. App. 1976) ("The manifest objective of a medical entity in including an arbitration clause is to avoid a jury trial and thereby hopefully minimize losses for any medical malpractice and correspondingly to hold down the amount of any recovery by the patient.").

163. Wheeler v. St. Joseph Hosp., 133 Cal. Rtpr. 775, 783 (Ct. App. 1976) (citation omitted).

164. Absent antitrust review, the patient will not be able to "bribe" providers into permitting litigation. While a new entrant into the local market could achieve differentiation by permitting litigation, the likelihood of adverse selection (i.e., of the

a clause will likely be labelled as both "harsh" and a product of "non-bargaining,"[165] and the clause will probably attract judicial scrutiny of its conscionability.[166]

It is surprising that only five state statutes have addressed the issue and expressly prohibited providers from making the execution of an arbitration clause a prerequisite to the provision of health care.[167] Of these, the Illinois statute makes it clear that the purpose of malpractice arbitration is limited to changing the style of, and forum for, dispute resolution. Further contractual "modifications" to substantive[168] or procedural[169] law are prohibited. Aside from its prophylactic effect, however, this is redundant. Any such limitation not authorized by statute would be analyzed as akin to an exculpatory clause and therefore voided.[170]

Tatham v. Hoke[171] illustrates that a court will hold *particularly* harsh terms substantively unconscionable despite the absence of such a statutory provision. In *Tatham*, a federal district court, applying North Carolina law, found that a $15,000 damage cap clause inserted into a malpractice arbitration agreement was unenforceable as contrary to public policy.

B. *Procedural Conscionability*

In this context, a conclusion of substantive unconscionability is the product of a judicial determination that one party (the provider) to the health care agreement has attempted to externalize excessively the legal risks that flow from the performance of the treatment contract. As has been demonstrated above, such provider attempts within the medical arbitration context have attracted both judicial and legislative dis-

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newcomer attracting informed, litigious patients) makes this unlikely.

165. Spanagle, *Analyzing Unconscionability Problems*, 117 U. PA. L. REV. 931, 948 (1969).

166. *See, e.g.*, Obstetrics & Gynecologists Ltd. v. Pepper, 693 P.2d 1259 (Nev. 1985).

167. ALASKA STAT. § 09-55-535(a) (1983); Health Care Arbitration Act § 8(a), ILL. ANN. STAT. ch. 10, § 208(a) (Smith-Hurd Supp. 1985); MICH. COMP. LAWS ANN. § 600.5041(2), .5042(2) (1975); Ohio Rev. Code Ann. § 2711.23(A) (Baldwin 1984); S.D. CODIFIED LAWS ANN. § 21-25B-3 (1979).

An agreement that remains true to the voluntary nature of consensual arbitration will not be stigmatized as substantively unconscionable. *See, e.g.*, Morris v. Metriyakool, 344 N.W.2d 736, 742, 756-57 (Mich. 1983); Strong v. Oakwood Hosp. Corp., 325 N.W.2d 435 (Mich. Ct. App. 1982); Jackson v. Detroit Memorial Hosp., 312 N.W.2d 212, 214 (Mich. Ct. App. 1981). This is particularly true if the agreement also includes a revocability provision.

168. Health Care Arbitration Act § 8(c), ILL. ANN. STAT. ch. 10, § 208(c) (Smith-Hurd Supp. 1985).

169. *Id.* § 8(d), ILL. ANN. STAT. ch. 10, § 208(d).

170. *See, e.g.*, Tunkl v. Regents of Univ. of Cal., 383 P.2d 441 (Cal. 1963).

171. 469 F. Supp. 914, 919 (W.D.N.C. 1979) (applying North Carolina law).

favor. A conclusion of procedural unconscionability, on the other hand, is the product of a judicial identification of excessive externalization of information costs associated with the arbitration agreement's *formation*, rather than the treatment contract's performance.[172]

The statutory provisions that state legislatures have enacted to satisfy procedural conscionability review of arbitration agreements effectively illustrate the practical overlap between procedural and substantive issues. Not only does legislation provide for the full and specific disclosure of the ramifications of arbitration agreements, but in some cases legislation also provides for the disclosure of statutorily mandated provisions designed to avoid challenge on substantive unconscionability grounds. For example, some statutes mandate "cooling-off" revocability periods, and others provide that execution of the arbitration agreement is not a prerequisite to the furnishing of health care. These statutes generally enforce disclosure and dictate the manner in which the disclosure is to be communicated, via the forms of the arbitration agreement itself.[173]

C. *Disclosure Models*

1. In General

There are two basic models for the preexecution disclosure of information about the terms of the arbitration agreement. The first model places the burden upon the health care provider to supply certain information to the patient. This burden will formally place a limitation upon the extent to which the provider may externalize the preexecution information costs, and therefore the legal risks, from the provider to the patient.[174] The second model conditions the agreement's validity upon the patient's having received preexecution independent advice. While this permits the provider to externalize preexecution information costs, it has the effect of replacing the patient's information costs with actual patient expenditure incurred in obtaining independent

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172. *See generally* Murray, *Unconscionability: Unconscionability,* 31 U. PITT. L. REV. 1, 25-26 (1969). In an effort to delineate the overlapping doctrines, one commentator has referred to "procedural" unconscionability as "bargaining naughtiness," and to "substantive" unconscionability as the "evils in the resulting contract." *See* Leff, *supra* note 151, at 487.

173. *See* ALASKA STAT. § 09-55-535(b)–(c) (1983); Health Care Arbitration Act § 9(d), ILL. ANN. STAT. ch. 10, § 209(d) (Smith-Hurd Supp. 1985); LA. REV. STAT. ANN. § 9-4235 (West 1983); MICH. COMP. LAWS ANN. §§ 600.5041(3),(5), .5042(3)–(4) (West 1975); OHIO REV. CODE. ANN. §§ 2711.23(A)–(B), .24 (Baldwin 1984); S.D. CODIFIED LAWS ANN. § 21-25B-3 (1979); VA. CODE § 8.01.581.12 (1984). *See also* CAL. CIV. PRO. CODE § 1295 (West 1982) (statutory compliance satisfies "validity" question).

174. Michigan's empirical study of patients and provider comprehension of malpractice arbitration is summarized in Mengel, *supra* note 136, at 335-37.

advice.[175] The former system of provider-disclosure has been the more popular in the drafting of today's medical malpractice arbitration statutes. Of the seven jurisdictions that have adopted this model, six are more or less specific about both the content and form of the agreement.[176] The regulation of form extends to both the conspicuousness of certain provisions within the arbitration agreement[177] and the conspicuousness of the arbitration agreement in relation to any other agreements entered into between the patient and the provider.[178] Further, Michigan mandates the delivery to the patient of an explanatory information brochure,[179] and Illinois provides for duplicative disclosure upon discharge.[180] In contrast, the Alaska statute, while it does mandate the content and form of the agreement to an extent, places the further responsibility for comprehensive regulation upon the attorney general.[181]

Two important legal issues, considered below,[182] arise from this provider-disclosure model. First, to what extent does provider compliance with statutory regulation of disclosure curtail judicial review of the agreement's procedural conscionability? Second, in jurisdictions where no such statutory regulation exists, to what extent will provider disclosure be mandated by the courts?

The second disclosure model, which calls for the rendering of independent preexecution advice to the patient, raises a different set of problems. As has been noted, "[a]lmost every written commercial transaction, except one hammered out by two lawyers representing two

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175. The patient still incurs some (albeit lesser) information costs: for example, the costs in finding, "What type of lawyer should I go to for advice? Who is the best lawyer in town to so advise me?"

176. *See* CAL. CIV. PRO. CODE § 1295(a)–(b) (West 1982); Health Care Arbitration Act §§ 8(b),(e), 9(a)–(b),(d)–(e), ILL. ANN. STAT. ch. 10, §§ 208(b),(e), 209(a)–(b),(d)–(e) (Smith-Hurd Supp. 1985); LA. REV. STAT. ANN. §§ 9-4231, –4235(1)–(2) (West 1983); MICH. COMP. LAWS ANN. §§ 600.5041(2)–(3), (5)–(6), .5042(2)–(4), (7) (West 1975); OHIO REV. CODE ANN. 2711.23 (A)–(E), (J) (Baldwin 1984); S.D. CODIFIED LAWS ANN. § 21-25B-3 (1979).

177. The most extensively regulated form is found in the Illinois statute. *See* Health Care Arbitration Act § 9, ILL. ANN. STAT. ch. 10, § 209 (Smith-Hurd Supp. 1985).

178. While it is quite possible that the parties will enter into simultaneous agreements, some statutes provide that the arbitration agreement must be separate from any other document. *See, e.g.*, Health Care Arbitration Act § 8(b), ILL. ANN. STAT. ch. 10, § 208(b) (Smith-Hurd Supp. 1985); OHIO REV. CODE ANN. § 2711.23(G) (Baldwin 1984). For an example of how a provider could put together a composite document, see Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 779 n.2 (Ct. App. 1976).

179. MICH. COMP. LAWS ANN. §§ 600.5041(6) (physicians), .5042(7) (hospitals) (West 1975).

180. Health Care Arbitration Act § 8(e), ILL. ANN. STAT. ch. 10, § 208(e) (Smith-Hurd Supp. 1985).

181. ALASKA STAT. § 09.55.535(b) (1983). Note that this provision only applies to pretreatment agreements.

182. *See infra* text accompanying notes 191-206.

individuals of equal bargaining power, is in a broad sense, a contract of adhesion."[183] The Georgia legislature has reacted by providing that "no agreement to arbitrate shall be enforceable unless the agreement was made subsequent to the alleged malpractice and after a dispute or controversy has occurred and *unless the claimant is represented by an attorney-at-law at the time the agreement is entered into.*"[184] Not only does this statute go farther in assuring procedural conscionability than any court would,[185] but inevitably it leads to speculation about whether *any* attorney would advise his client to execute a medical malpractice arbitration agreement.

The legal ramifications are serious. First, the patient-client may try to disavow an agreement to arbitrate entered into between her attorney (purporting to act as her agent) and the provider.[186] Second, if the patient-client herself executes the agreement upon legal advice, there may arise the potential for *legal* malpractice litigation. It is unlikely that the courts would adopt a per se negligence rule to reflect a conclusion that it is *always* against the client-patient's interests to advise arbitration rather than litigation of a claim. Yet litigation would be invited in circumstances involving, for example, one-sided arbitration agreements[187] or very good jury cases.[188] Even if a court concluded that there was no legal malpractice in the substance of the proffered advice, the plaintiff-patient might be able to construct an informed consent malpractice claim.[189] After all, "[a]n attorney should explain to the client the strategic considerations that determine whether a jury trial or some other form of dispute resolution should be utilized."[190] Thus, the attorney may be liable, not for negligently given advice, but for negligently failing to inform his client of the ramifications of that advice.

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183. Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 797 (Ct. App. 1976) (Gardner, J., dissenting).

184. GA. CODE ANN. § 7-403 (Supp. 1981) (emphasis added). Note also Texas' general arbitration statute, which has a similar provision with regard to the arbitration of all personal injury claims. TEX. REV. CIV. STAT. ANN. art. 224(c) (Vernon 1973). SEE ALSO N.C.R. Corp. v. Mr. Penguin Tuxedo Rental & Sales, 663 S.W.2d 107 (Tex. Ct. App. 1983).

185. *See, e.g.*, Guadano v. Long Island Plastic Surgical Group, 607 F. Supp. 136, 139 (E.D.N.Y. 1982).

186. *See infra* text accompanying notes 297-99.

187. *See, e.g.*, the "agreement" executed in Blanton v. Womancare Inc., 696 P.2d 645, 647 (Cal. 1985) (en banc).

188. For example, a case with a visibly disabled plaintiff or with deposition testimony suggesting "modifications" made to patient records would have jury appeal.

189. *See generally* Martyn, *Informed Consent in the Practice of Law*, 48 GEO. WASH. L. REV. 307 (1979); Spiegel, *Lawyering and Client Decisionmaking: Informed Consent and the Legal Profession*, 128 U. PA. L. REV. 41 (1979).

190. Blanton v. Womancare Inc., 696 P.2d 645, 656 (Cal. 1985) (en banc) (Bird, C.J., concurring).

Given the various legislative attempts to provide the patient with information before the execution of an arbitration agreement, the first question for consideration is the effect that provider compliance with that legislative mandate will have on the agreement. The answer appears to be that so long as there is *strict* compliance, the agreement will be considered procedurally conscionable,[191] and additional information need not be disclosed by the provider.[192]

Three additional points should be stressed. First, judicial insistence upon strict compliance with statutory provisions will overcome the policy of attempting to construe arbitration agreements in favor of arbitration.[193] Second, the judicially espoused rule of strict compliance will effectively mandate a hearing on the issue whenever raised by the patient-plaintiff.[194]

Third, strict compliance with the statutory regime will not necessarily foreclose review of the circumstances surrounding such compliance. Of course, that begs the question—what circumstances will provide grounds for nonenforcement of the arbitration agreement? Courts seem quite happy to recite that any arbitration agreement must have been entered into "knowingly, intelligently, and voluntarily."[195] Granted, they will entertain case-by-case review of accusations of coer-

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191. *See, e.g.*, Rosenfield v. Superior Court, 191 Cal. Rptr. 611, 613-14 (Ct. App. 1983); Roberts v. McNamara-Warren Community Hosp., 360 N.W.2d 279, 281 (Mich. Ct. App. 1984); Ewald v. Pontiac Gen. Hosp., 329 N.W.2d 495, 497 (Mich. Ct. App. 1982); Horn v. Cooke, 325 N.W.2d 558, 562 (Mich. Ct. App. 1982); Rome v. Sinai Hosp., 316 N.W.2d 428, 430 (Mich. Ct. App. 1982). *Cf.* Moore v. Fragatos, 321 N.W.2d 781, 789-90 (Mich. Ct. App. 1982) (record must affirmatively show that plaintiff was aware he was signing arbitration agreement).

192. For example, it will be unnecessary for the provider to inform the patient about the relative merits of arbitration. *See, e.g.*, Morris v. Metriyakool, 344 N.W.2d 736, 757 (Mich. 1984); Brown v. Siang, 309 N.W.2d 575, 581 (Mich. Ct. App. 1981).

193. Ewald v. Pontiac Gen. Hosp., 329 N.W.2d 495, 497 (Mich. Ct. App. 1982). *Cf.* Kukowski v. Piskin, 297 N.W.2d 612, 613 (Mich. Ct. App. 1980), *aff'd*, 327 N.W.2d 832 (Mich. 1982) ("Arbitration clauses are to be liberally construed, with all doubts about the arbitralility of an issue resolved in favor of arbitration.") (citation omitted).

194. May v. St. Luke's Hosp., 363 N.W.2d 6 (Mich. Ct. App. 1984). *See also*, Rome v. Sinai Hosp., 316 N.W.2d 428, 430 (Mich. Ct. App. 1982); Pipper v. DiMusto, 279 N.W.2d 542 (Mich. Ct. App. 1979). With regard to the burden of proof in such circumstances, see Moore v. Fragatos, 321 N.W.2d 781 (Mich. Ct. App. 1982). *Cf.* Manuel v. Pierce, 328 N.W.2d 633, 634-35 (Mich. Ct. App. 1982) (Danhof, C.J., stating in dissent that the burden of proof on the validity of the agreement does not necessarily rest with the defendant). Of course, there may be no need for a hearing if there is uncontroverted or objective evidence of noncompliance. *See* Rosenfield v. Superior Court, 191 Cal. Rptr. 611 (Ct. App. 1983); Roberts v. McNamara-Warren Community Hosp., 360 N.W.2d 279 (Mich. Ct. App. 1984); Ewald v. Pontiac Gen. Hosp., 329 N.W.2d 495 (Mich. Ct. App. 1982).

195. *See, e.g.*, Roberts v. McNamara-Warren Community Hosp., 360 N.W.2d 279, 281 (Mich. Ct. App. 1984). *See also* Ford v. Shearson Lehman/American Express Inc., 225 Cal. Rptr. 895, 904-05 (Ct. App. 1986).

cion,[196] misrepresentation,[197] or mistake.[198] Courts seem less willing, however, to entertain arguments of plaintiff-patient illiteracy.[199] To complicate matters further, a patient's allegation that she signed the agreement while in considerable pain may be reviewed either under the general principles of procedural conscionability described above,[200] or on the basis of an explicit statutory provision that effectively removes an "emergency patient"[201] from the scope of statutory arbitrability.[202]

Clearly, different issues arise in jurisdictions that do not mandate preexecution disclosure. For example, the Supreme Court of Nevada refused to enforce an arbitration agreement in which the provider offered to answer questions the patient may have had with regard to the agreement, but did not disclose to her its terms and effect.[203] A similar result was reached by a California appellate court in *Wheeler v. St. Joseph Hospital*.[204] That case involved an arbitration clause in a hospital admission/consent form. The clause did not condition treatment upon agreeing to arbitration, and it did provide for revocation. Nevertheless, the court characterized the contract as one of adhesion,[205] stating:

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196. *See, e.g.*, Ramirez v. Superior Court, 163 Cal. Rptr. 223 (Ct. App. 1980); McKinstry v. Valley Obstetrics-Gynecology Clinic, 327 N.W.2d 507, 509 (Mich. Ct. App. 1982); Capman v. Harper-Grace Hosp., 294 N.W.2d 205 (Mich. Ct. App. 1980).

197. *See, e.g.*, Horn v. Cooke, 325 N.W.2d 558, 561 (Mich. Ct. App. 1982).

198. *See, e.g.*, Guadano v. Long Island Plastic Surgical Group, 607 F. Supp. 136 (E.D.N.Y. 1982).

199. *See, e.g.*, Horn v. Cooke, 325 N.W.2d 558, 561-62 (Mich. Ct. App. 1982). *Cf.* Aluia v. Harrison Community Hosp., 362 N.W.2d 783 (Mich. Ct. App. 1984) (genuine issue of material fact existed whether Italian-speaking patient had made knowing, voluntary, and intelligent waiver of right to jury trial); Ramirez v. Superior Court, 163 Cal. Rptr. 223, 227-28 (Ct. App. 1980) ("adhesion contract" exception to "duty to read" requirement applied in favor of Spanish-speaking patient).

Consider also the burden of proof applicable to such cases as provided for by OHIO REV. CODE ANN. § 2711.24 (Baldwin 1984) (preponderance of the evidence needed to rebut presumption of validity).

This reluctance may be attributed to the duty to read imposed by general contract law. *See* Guadano v. Long Island Plastic Surgical Group, 607 F. Supp. 136, 139 (E.D.N.Y. 1982). *See also* J. CALAMARI & J. PERILLO, THE LAW OF CONTRACTS §§ 9-41 to 9-46 (2d ed. 1977).

200. For an additional example, see Moore v. Fragatos, 321 N.W.2d 781, 790 (Mich. Ct. App. 1982).

201. *See* MICH. COMP. LAWS ANN. § 600.5042(1) (West 1975).

202. *See, e.g.*, May v. St. Luke's Hosp., 363 N.W.2d 6 (Mich. Ct. App. 1984); Pipper v. DiMusto, 279 N.W.2d 542, 544 (Mich. Ct. App. 1979).

203. Obstetrics & Gynecologists Ltd. v. Pepper, 693 P.2d 1259, 1261 (Nev. 1985).

204. 133 Cal. Rptr. 775 (Ct. App. 1976).

205. *See id.* at 785. The agreement in question was executed prior to CAL. CIV. PRO. CODE § 1295 (West 1982). California now follows the "strict compliance" approach. *See* Rosenfield v. Superior Court, 191 Cal. Rptr. 611, 613-14 (Ct. App. 1983).

> We conclude that in order to be binding, an arbitration clause incorporated in a hospital's "CONDITIONS OF ADMISSION" form should be called to the patient's attention and he should be given a reasonable explanation of its meaning and effect, including an explanation of any options available to the patient.[206]

2. Group Health Plans and Conscionability

In characterizing the arbitration clause in *Wheeler* as adhesive, the majority of the court distinguished[207] a contrary finding in *Madden v. Kaiser Foundation Hospitals*,[208] on the basis that *Madden* had involved a group health plan. The subsequent California statute has confirmed the apparently distinctive nature of group plans by excusing them from compliance with otherwise mandated disclosure, form of disclosure, and revocability provisions.[209] The courts have developed this distinction further by apparently changing the rules of the agency "game" to reflect their view of the reality of group health plan negotiation.[210]

Madden expresses the apparent rationale for this different treatment of group health plans:

> In the characteristic adhesion contract case, the stronger party drafts the contract, and the weaker has no opportunity, either personally or through an agent, to negotiate concerning its terms.
>
> The [group] plan, on the other hand, represents the product of negotiation between two parties, [the provider] and [the employer], possessing parity of bargaining strength. Although plaintiff did not engage in the personal negotiation of the contract's terms, she and other . . . employees benefitted from representation by [an employer-group], composed in part of persons elected by the affected employees, which exerted its bargaining strength to secure medical protection for employees on more favorable terms than any employee could

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206. *Wheeler*, 133 Cal. Rptr. at 786. Note how a different result may obtain if these issues are raised at the post-award stage. *See* Lamb v. Holy Cross Hosp., 148 Cal. Rptr. 273 (Ct. App. 1978).

207. Indeed, the majority emasculated Madden v. Kaiser Found. Hosps., 552 P.2d 1178 (Cal. 1976) (en banc), at least according to the *Wheeler* dissent. 133 Cal. Rptr. at 795 (Gardner, P.J., dissenting). *See* Davis v. Blue Cross, 600 P.2d 1060, 1061 n.1 (Cal. 1979) (en banc).

208. 552 P.2d 1178 (Cal. 1976) (en banc).

209. CAL. CIV. PRO. CODE § 1295(f) (West 1982) (excusing group plans from § 1295(a)-(c)). *See also* Dinong v. Superior Court, 162 Cal. Rptr. 606 (Ct. App. 1980) (holding, *inter alia*, that (1) this provision of the California statute did not violate equal protection guarantees by distinguishing between individuals and group plan enrollees with regard to preagreement disclosure; and (2) technical nonqualification of a group health provider during a state administrative reorganization was not sufficient to place the provider outside of the exemption of § 1295(f)).

210. *See infra* text accompanying notes 305-10.

individually obtain.[211]

Of course, this conjures up an unrealistic picture of two parties, each with perfect information, hammering out a contract to the benefit of the employee-patient. It falsely presumes that the interests of the employer are identical and co-extensive with those of the employee. In reality, the employer is willing to trade the *employee's* litigation rights for lower *employer*-incurred costs.

In any event, both *Madden* and the California statute deal with the *disclosure* of the arbitration clause. A problem may also arise with regard to a group provider making arbitration a prerequisite to the provision of health care (i.e., refusing to negotiate the issue of arbitration). In South Dakota, a jurisdiction that prohibits such a provider stance,[212] a health maintenance organization argued that the insertion of a mandatory arbitration clause in its enrollee contracts was a prerequisite to *enrollment* rather than to the *provision of health care*, a position that the South Dakota attorney general not surprisingly refused to accept.[213]

VIII. REVOCABILITY ISSUES

At common law, a party to an arbitration agreement could revoke her submission to arbitrate prior to the making of an award.[214] The other party could then pursue an orthodox breach of contract action.[215] In contrast, the Uniform Arbitration Act of 1955[216] provides that an arbitration agreement "is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract."[217] Similar language has been expressly adopted in five medical malpractice statutes.[218] In this context, "revocation" seems more akin

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211. *Madden*, 552 P.2d at 1185 (citations omitted). *Cf.* Victoria v. Superior Court, 222 Cal. Rptr. 1, 6 (1985) (avoiding the *Madden* approach by holding that "unlike *Madden*, it is *not* clear from the record whether petitioner's father had an opportunity to select an alternative health care plan which did not require arbitration").

212. S.D. CODIFIED LAWS ANN. § 21-25B-3 (1979). For the other states, see *supra* note 167.

213. 1975-76 Op. Att'y Gen. S.D. 667, 670 (No. 76-98).

214. *See, e.g.*, Lerma v. Allstate Ins. Co., 301 F. Supp. 361 (D. Ind. 1968). *See generally* G. WILNER, *supra* note 1, § 3.01. *See also* cases cited at UNIF. ARBITRATION ACT § 1 n.2, 7 U.L.A. 1, 4 (Supp. 1985).

215. *See, e.g.*, Brown v. Eubank, 443 S.W.2d 386 (Tex. Civ. App. 1969). *Cf.* Nassau Ins. Co. v. McMorris, 363 N.E.2d 700, 701 (N.Y. 1977) ("[Q]uestions as to whether the agreement has been terminated . . . have customarily been held to be for the arbitrator.").

216. UNIF. ARBITRATION ACT § 1, 7 U.L.A. 4 (1978).

217. *Id.*, 7 U.L.A. at 4.

218. *See* ALA. CODE § 6-5-485(a) (1975); LA. REV. STAT. ANN. § 9-4232 (West 1983); OHIO REV. CODE ANN. § 2711.22 (Baldwin 1984); S.D. CODIFIED LAWS ANN. §

to "rescission," in which case the grounds for rescission would be limited to traditional contractual ones such as fraud, duress, mistake, and unconscionability.[219]

Additionally, seven malpractice arbitration statutes contain very specific provisions permitting a patient to "revoke" the agreement within a certain time frame.[220] Conceptually more closely related to the Uniform Consumer Credit Code's[221] right of cancellation,[222] these types of provisions provide the patient with a "cooling-off" period in which to reconsider her agreement to arbitrate. Current statutes usually provide a period of thirty or sixty days in duration. There is considerable variation in the time from which this period begins to run; it may run from the execution of the agreement,[223] discharge from the hospital,[224] termination of care,[225] or termination of the physician-patient relationship.[226] Some statutes toll the revocation period in the case of continuing ill health[227] or incapacity of the patient.[228] While written notice of exercise of the right of revocation is expressly demanded in most of the revocation provisions, those that are silent on this issue do not expressly prohibit the health care provider from including this formality as a condition.[229] The Ohio statute is unique in providing that the filing of a medical malpractice claim within the cooling-off period

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21-25A-1 (1979) (applicable to medical malpractice arbitration through § 21-25B-1); VA. CODE § 8.01-577(B) (1984) (applicable to medical malpractice arbitration through § 8.01-581.12.A).

219. *See supra* text accompanying notes 148-73.

220. ALASKA STAT. § 09-55-535(c) (1983); CAL. CIV. PRO. CODE § 1295(c) (West 1982); Health Care Arbitration Act § 9(c), ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1985); LA. REV. STAT. ANN. § 9-4233 (West 1983); Mich. Comp. Laws Ann. §§ 600.5041(3), .5042(3) (West 1975); Ohio Rev. Code Ann. § 2711.23(B) (Baldwin 1984); VA. CODE § 8.01-577(B) (1984). *See also* S.D. COFIFIED LAWS ANN. § 21-25B-1 (1979), which, while not permitting revocation, does allow the arbitration contract for future services to be terminated.

221. UNIF. CONSUMER CREDIT CODE § 2.502, 7 U.L.A. 384-85 (1978). *See also* Rosenfield v. Superior Court, 191 Cal. Rptr. 611, 614 (Ct. App. 1983).

222. UNIF. CONSUMER CREDIT CODE § 2.502, 7 U.L.A. 384-85 (1978).

223. ALASKA STAT. § 09-55-535(c) (1983); CAL. CIV. PRO. CODE § 1295(c) (West 1982); LA. REV. STAT. ANN. § 9-4233 (West 1983); MICH. COMP. LAWS ANN. § 600.5041(3) (West 1975).

224. Health Care Arbitration Act § 9(c), ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1985); MICH. COMP. LAWS ANN. § 600. 5042(3) (West 1975); OHIO REV. CODE ANN. § 2711.23(B), (I) (Baldwin 1984).

225. VA. CODE § 8.01-581.12.A (1984).

226. OHIO REV. CODE ANN. § 2711.23(B) (Baldwin 1984).

227. ALASKA STAT. § 09-55-535(c) (1983).

228. VA. CODE § 8.01.581.12 (1984). In this instance, the period runs from the date of appointment of a legal representative.

229. *See, e.g.*, Health Care Arbitration Act § 9(c), ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1985) (any signatory may cancel); VA. CODE § 8.01.581.12 (1984) (valid if withdrawal is allowed).

automatically revokes the arbitration agreement.[230] Only the Louisiana statute addresses the potentially troublesome problem of the alleged malpractice occurring within the cooling-off period, and it provides that the revocation is effective only with regard to subsequent claims.[231]

Several difficult problems remain for consideration. First, in the case of malpractice arbitration statutes that are silent on the issue of revocability,[232] are patients permitted to withdraw ("revoke") their consent? One possible option would be for a court to remain true to the voluntary nature of alternative dispute resolution and permit revocation, with reasonable notice,[233] up to the submission of the claim to the arbitrators.[234]

A second problem will arise when a patient dies or becomes incapacitated during the revocation period. While some statutes provide specifically that the revocation right in such a case passes to the patient's legal representative,[235] only the Illinois and Virginia statutes expressly toll the revocation period until the representative is appointed.[236] To deal with such legislative lacunae, the Michigan courts have been forced to introduce tolling provisions in situations involving a patient's incapacity[237] or death.[238]

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230. OHIO REV. CODE ANN. § 2711.23(I) (Baldwin 1984).

231. LA. REV. STAT. ANN. § 9-4233 (West 1983). In addition to such revocation provisions, some statutes provide for the automatic lapse of the agreement after either a certain period or a given contingency. For examples of the automatic time lapse, see Health Care Arbitration Act § 9(c), ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1985); LA. REV. STAT. ANN. § 9-4236 (West 1983); MICH. COMP. LAWS ANN. § 600.5041(4) (1975). *See also* MICH. COMP. LAWS ANN. § 600.5042(6) (West 1975) (contingency lapse upon fresh admission to hospital).

232. *See e.g.*, GA. CODE ANN. §§ 9-9-110 to -133 (1981). Consider, however, that this Georgia statute allows medical malpractice arbitration only of existing controversies and only if the claimant is represented by counsel. Query, then, whether a revocation provision is necessary. *See* GA. CODE ANN. § 9-9-112 (1981).

233. *See, e.g.*, City of Beverly v. White, Hamele & Assocs., 580 P.2d 1321 (Kan. 1978) (common-law agreement revocable); Marsello v. Barnett, 236 A.2d 869, 874 (N.J. 1967) ("[A plaintiff is] bound to give reasonably early notice of his intention to withdraw. . . . Where such notice is unreasonably delayed, the other party would be entitled to reimbursement for expenses incurred.").

234. *See, e.g.*, Grove v. Seltzer, 266 A.2d 301 (N.J. 1970). *See also* Marsello v. Barnett, 236 A.2d 869, 874 (N.J. 1967).

235. OHIO REV. CODE ANN. § 2711.23(B) (Baldwin 1984); MICH. COMP. LAWS ANN. §§ 600.5041(3), .5042(3) (West 1975).

236. Health Care Arbitration Act § 9(c), ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1985); VA. CODE § 8.01-581.12.A (1984). Alaska has a physical incapacity tolling provision. *See* ALASKA STAT. § 09-55-535(c) (1983). The Louisiana statute circumvents the problem by prohibiting revocation if the act of malpractice has already occurred. If one presumes that the act of malpractice will have occurred prior to the patient's death, there will be no revocation right to be passed on to a representative, let alone to be tolled. *See* LA. REV. STAT. ANN. § 9:4233 (West 1983).

237. Amwake v. Mercy-Memorial Hosp., 285 N.W.2d 369, 372-73 (Mich. Ct. App. 1979) (comatose patient given 60 days from the time her disability was removed

Further, in *Edwards v. St. Mary's Hospital*,[239] in which the husband of a comatose patient purported to revoke his wife's arbitration agreement with the defendant before being appointed administrator of her estate, the appellate court refused an overly technical reading of the Michigan revocability provision. Instead, the court held that "[i]t appears natural to include a husband within the term 'legal representative' when his wife is comatose. Under normal circumstances the husband will look out for his wife's business and best interests."[240]

In addition to these technical considerations, there arises a far more important conceptual, and yet practical, problem. Presume that a patient executed an arbitration agreement upon admission to a hospital and that the patient read and understood the arbitration clause. Why would the patient want to revoke that agreement within thirty days? Why would the patient even think about the arbitration agreement within the next thirty days? In the context of, say, a consumer credit application, the effect of the signature becomes obvious to the consumer almost immediately. The proximity of that first payment concentrates the consumer's mind on the advisability of the credit purchase. For the patient, however, the only tangible reminder of the existence of the arbitration agreement will be when she brings a malpractice claim, an event unlikely to occur within the brief revocation period. Is it safe to say that it is this factor which explains the low patient use of revocation?[241]

IX. Scope of the Medical Malpractice Arbitration Statute

A legislative body that simply establishes an arbitration scheme for "persons asserting a claim based on medical malpractice"[242] pays

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to revoke the arbitration agreements).

238. Boiko v. Henry Ford Hosp., 313 N.W.2d 344, 346-47 (Mich. Ct. App. 1981) (legal representative has 60 days from date of appointment to revoke decedent's previously signed arbitration agreement); DiPonio v. Henry Ford Hosp., 311 N.W.2d 754, 757-58 (Mich. Ct. App. 1981) (coadministrators had 60 days from first notice of arbitration agreement to expiration of revocation period).

In general, it appears that, since a failure to revoke an arbitration agreement does not have the effect of *barring* the plaintiff's action, the judiciary will not be favorably disposed towards applying any "discovery" rule from which the revocation period would run. *See* Capman v. Harper-Grace Hosp., 294 N.W.2d 205, 208 (Mich. Ct. App. 1980). Similarly, the judiciary will be hesitant to introduce other tolling provisions, such as one for the fraudulent concealment of the existence of a cause of action. *See, e.g.*, Swope v. Printz, 468 S.W.2d 34 (Mo. 1971).

239. 356 N.W.2d 255 (Mich. Ct. App. 1984).

240. *Id.* at 257.

241. *See* Ludlam & Hassard, *Arbitration*, HOSPITAL, Oct. 1, 1970, at 58, 81 (discussion of a study indicating that less than one-tenth of one percent of admitted patients reject offered arbitration contracts or provisions).

242. *See* VT. STAT. ANN. tit. 12, § 7002 (Supp. 1985).

scant regard to the legal ingenuity of the malpractice bar. Even if the courts recognize a "strong public policy . . . favoring arbitration"[243] and construe agreements to favor arbitration,[244] difficult problems of interpretation arise. For example, it may be difficult to identify the parties intended by legislatures to be permitted to use the prescribed schemes, and there may be problems in defining the types of conduct and claims to be considered arbitrable.

In general terms, the scope of an arbitration agreement—and thus, the parties and type of conduct included—is a matter for the arbitrators.[245] After all, the arbitrator will determine the intention of the parties regarding the breadth of the submission to arbitration. This is not true, however, with regard to questions relating to arbitrability as a matter of law or to the scope of arbitration facilitating statutes.[246] Just as a claimant may resist arbitration on the basis of a *judicial* determination of substantive or procedural unconscionability,[247] so may she resist because the agreement falls outside the scope of the statutory arbitration provision.[248] As one court stated with regard to the former scenario, "[c]ompulsory submission to arbitration cannot precede a judicial determination of the validity of the agreement itself."[249] Indeed, once the patient has raised the issue of noncompliance, a provider is

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243. Beynon v. Garden Grove Medical Group, 161 Cal. Rptr. 146, 149 (Ct. App. 1980). *See also* Menardi v. Petrigalla, 462 N.E.2d 1246, 1249 (Ohio Ct. App. 1983).

244. *See, e.g.*, Kukowski v. Piskin, 297 N.W.2d 612, 613 (Mich. Ct. App. 1980), *aff'd*, 327 N.W.2d 832 (Mich. 1982) ("Arbitration clauses are to be liberally construed, with all doubts about the arbitrability of an issue resolved in favor of arbitration.").

245. *But see* GA. CODE ANN. § 9-9-112 (1981) (scope of agreement is for judge to determine).

246. *See generally* Henderson, *supra* note 2, at 971-76; Henderson, *Alternatives*, *supra* note 155, at 329-31. *See also* Bel Pre Medical Center v. Frederick Contractors, Inc., 320 A.2d 558 (Md. Ct. Spec. App. 1974) (arbitrator decides procedural issues of claim), *rev'd*, 334 A.2d 526 (Md. 1975) (procedural timeliness of submission to arbitration is question for judge, not arbitrator); AT&T Technologies v. Communications Workers of Am., No. 84-1913, slip op., 54 USLW 4339, 4341.

> It is the court's duty to interpret the agreement and to determine whether the parties intended to arbitrate grievances concerning layoffs predicated on a "lack of work" determination by the Company. If the court determines that the agreement so provides, then it is for the arbitrator to determine the relative merits of the parties' substantive interpretations of the agreement. It was for the court, not the arbitrator, to decide in the first instance whether the dispute was to be resolved through arbitration.

247. *See supra* text accompanying notes 148-73.

248. *Cf.* Herrera v. Superior Court, 204 Cal. Rptr. 553 (Ct. App. 1984) (statutory language sets threshold of arbitrable actions and does not limit disputes to the constraints of that language). A later decision by this California appellate court seems both to agree with and to contradict the *Herrara* opinion. *See* Baker v. Sadick, 208 Cal. Rptr. 676 (Ct. App. 1984).

249. Capman v. Harper-Grace Hosp., 294 N.W.2d 205, 207 (Mich. Ct. App. 1980).

"required to establish that an arbitration agreement was knowingly, intelligently, and voluntarily entered into by the plaintiff in strict compliance with the malpractice arbitration act."[250]

It should be noted that there are some "scope of agreement" issues that do not involve such difficult legal problems. For example, in *Troy v. Leep*,[251] a patient executed an arbitration agreement applying to claims *arising out of* her hospital treatment. The court remanded the cause for trial and did not compel arbitration, since the plaintiffs' petition alleged provider negligence which had in fact *preceded* the patient's hospitalization.[252]

A. *Defendants*

Some arbitration statutes make use of the superficially all-inclusive phrase "health care provider,"[253] and some make use of a referential definition by way of unrelated state provisions such as licensure statutes.[254] Still other statutes provide exhaustive lists of potential defendants who may take advantage of the arbitration option.[255] Thus, the statutory draftsmen have not always dealt adequately with the inclusion or exclusion of, for example, pharmacists, dentists, health main-

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250. Roberts v. McNamara-Warren Community Hosp., 360 N.W.2d 279, 281 (Mich. Ct. App. 1984). In addition to those issues identified in the arbitration statutes themselves, some problems pertaining to scope have been litigated in the context of mandatory medical malpractice review panels. Although it might be thought that stricter, narrower construction would be employed by a court interpreting such nonelective schemes, in practice this does not seem to follow. The courts of a jurisdiction that have upheld such a review panel against constitutional challenge are generally favorably disposed towards wide use of review panels.

251. 300 N.W.2d 598 (Mich. Ct. App. 1980). *See also* Miller v. Swanson, 289 N.W.2d 875 (Mich. Ct. App. 1980). There will be transitional "timing" problems as well, depending upon the effective date of the applicable statute. *See, e.g.*, Oxtoby v. McGowan, 447 A.2d 860 (Md. 1982) (actions for medical injuries occurring before the effective date of the statute are not subject to it).

252. *Troy*, 300 N.W.2d at 599.

253. *E.g.*, ALASKA STAT. § 09-55-535(a) (1983).

254. *E.g.*, CAL. CIV. PRO. CODE § 1295 (g)(1) (West 1982). *See also* LaCroix v. Caron, 423 A.2d 247 (Me. 1980) (held that podiatrists are not physicians within a licensure act referentially included into the malpractice notification provisions).

255. Examine, for example, the Virginia statute:

> *"Health care provider"* means a person, corporation, facility or institution licensed by this Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, physical therapy assistant, clinical psychologist or a nursing home . . . except those nursing institutions conducted by and for those who rely upon treatment by spiritual means alone through prayer in accordance with a recognized church or religious denomination, or an officer, employee or agent thereof acting in the course and scope of his employment.

VA. CODE § 8.01-581.1 (1984)

tenance organizations,[256] nursing homes, and the manufacturers and suppliers of drugs and surgical equipment.

It may be argued that the purpose of existing malpractice arbitration statutes is to deal with claims that involve the care and treatment arising directly out of a provider-patient relationship. Thus, a claim brought against a physician-author of a diet book would fall outside that statutory purpose.[257] A court would undoubtedly find, however, that an allegation of improper treatment and care rendered by an ambulance service, other than negligent driving,[258] would come within the arbitration statute, as would a misdiagnosis by an independent medical laboratory.[259]

Aside from such threshold questions of whether an arbitration agreement may extend as a matter of law to a particular defendant, problems of interpreting the scope of agreements will arise in the identification of specific defendants included in the agreement to arbitrate.[260] Consider, for example, the interpretation of an agreement to arbitrate entered into between a patient and a hospital which expressly provided that its scope extended to claims against independent staff doctors. The Michigan courts have decided that a binding agreement to arbitrate exists between the independent staff doctor and the patient in such a case,[261] provided that there is evidence that the doctor in question executed an agreement to arbitrate with the hospital *before* the execution of the hospital-patient agreement.[262]

B. *Counterclaims, Joinder, Contribution, and Indemnity*

Counterclaims pose two obvious problems. First, consider the situation in which a hospital brings an action against a discharged patient for her unpaid bill. The defendant replies that the unpaid fees were the result of her extended hospitalization, which was itself caused by the

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256. *See, e.g.*, Group Health Ass'n v. Blumenthal, 453 A.2d 1198, 1202-03 (Md. 1983) (court interpreted arbitration statute not to cover health maintenance organizations).

257. Smith v. Linn, 414 A.2d 1106 (Pa. Commw. Ct. 1980).

258. Sigmon v. County of Tompkins, 449 N.Y.S.2d 621 (Sup. Ct. 1982).

259. Calvin v. Schlossman, 427 N.Y.S.2d 632 (App. Div. 1980).

260. Some of these problems may be circumvented at the legislative level by mandating the form of the arbitration agreement. *See, e.g.*, ALASKA STAT. § 09-55-535(b) (1983) (requires prior approval of the agreement's form by the attorney general).

261. Kukowski v. Piskin, 297 N.W.2d 612 (Mich. Ct. App. 1980), *aff'd*, 327 N.W.2d 832 (Mich. 1982).

262. Belobradich v. Sarnsethsiri, 346 N.W.2d 83 (Mich. Ct. App. 1983) (hospital-physician arbitration agreement executed several months after hospital-patient agreement). This can be contrasted with the issues arising in a mandatory arbitration involving a respondeat superior suit. *See, e.g.*, Group Health Ass'n v. Blumenthal, 453 A.2d 1198 (Md. 1983).

plaintiff's malpractice. If the defendant's reply is considered a counterclaim rather than a defense, it is a "claim" and, arguably, should be submitted to arbitration.[263] Consider the converse situation, in which the patient submits her malpractice claim to arbitration and the defendant hospital counterclaims for an unpaid bill[264] or for the loss of reputation and business.[265] If the scope of the arbitration agreement is phrased in terms of "any controversy arising out of claims based on negligence or medical malpractice,"[266] the issue is far from clear. The counterclaim may be a "controversy" arising out of the malpractice "claim," but it is not a "claim" based on malpractice or negligence. Furthermore, being a contractual claim, it may be outside the competence of a specialized arbitration panel comprised, at least in part, of physicians or personal injury attorneys.

In any event, it is clear that counterclaim situations involve only the existing parties to the arbitration agreement. As the parties proliferate, however, so exponentially do the problems. The case of *Staub v. Southwest Butler County School District*,[267] decided with reference to Pennsylvania's then extant mandatory arbitration/mediation scheme, concerned a personal injury suit brought by a high school student following a fall. The defendant school district joined the health care providers who had treated the plaintiff following her fall. The health care providers objected on the basis that the arbitration panel had exclusive original jurisdiction over malpractice claims against them. Since the plaintiff had not filed a claim against the health care providers and the defendant third party plaintiff was entitled to seek contribution from them, the court permitted joinder.[268] As was pointed out in the concurrence,

> [t]he opportunities for abuse are manifest. If a plaintiff wants to avoid the arbitration panel (and she may have good reasons for doing so . . .), then plaintiff need only sue a nonhealth care provider as an original defendant, and allow him in turn to join the health care provider. Collusion will not be necessary. The plaintiff can simply serve a nonhealth care defendant with a complaint replete with allegations of medical malpractice, and may be assured that the named

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263. *See, e.g.*, Armstrong County Memorial Hosp. v. Vitolo, 10 Pa. D. & C.3d 791 (Pa. C. 1979).

264. *See, e.g.*, Bonk v. Block, 12 Pa. D. & C.3d 749 (Pa. Admin. Arbitration Panels for Health Care 1980) (cases dealing with Pennsylvania's mandatory pretrial mediation system); Loverdi v. Mercy Catholic Medical Center, No. M77-0383 (Pa. Admin. Arbitration Panels for Health Care 1978).

265. *See, e.g.*, Joyce v. Central Medical Health Serv., 12 Pa. D. & C.3d 666 (Pa. Admin. Arbitration Panels for Health Care 1978).

266. LA. REV. STAT. ANN. § 9:4231 (West 1983) (sample arbitration agreement).

267. 398 A.2d 204 (Pa. Super. Ct. 1979).

268. *Id.* at 207. *See also* Zielinski v. Zappala, 470 F. Supp. 351 (E.D. Pa. 1979); Walt Disney World v. Memorial Hosp., 363 So. 2d 598 (Fla. 1978).

> defendant, seeking exculpation or contribution, will join the health care provider as an additional defendant.[269]

Clearly, however, this situation will only arise when the defendant nonprovider brings in the provider. If the plaintiff patient brings the nonprovider in as a codefendant, this will not serve to avoid arbitration of the patient-provider claim. Indeed, the court may sever the claims, compelling arbitration on the action between the patient and the provider, while proceeding to litigation on the suit between the patient and the nonprovider.[270]

In the context of a voluntary arbitration agreement, the converse situation, in which the patient submits a claim against a health care provider to arbitration and the health care provider seeks to bring in the nonprovider as an additional defendant, is less likely to occur. The reason is obvious; if the patient voluntarily executed a postclaim arbitration agreement with *both* the health care provider and the nonprovider, she has contractually agreed to "joinder."[271] If, on the other hand, the plaintiff had executed a pretreatment agreement with the health care provider while agreeing also to arbitrate claims against nonproviders, not only would the latter have to be identified in the agreement, but they would also have to have executed a prior agreement with the health care provider in order to be joined.[272]

Two medical malpractice arbitration statutes have derogated from this consensual model. In Michigan, any existing party to the arbitration agreement may join *any* other party if that third party agrees to joinder.[273] Illinois permits joinder of third parties without their agree-

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269. *Staub*, 398 A.2d at 209 (citation and footnote omitted).

270. Madden v. Kaiser Found. Hosps., 552 P.2d 1178, 1187-88 (Cal. 1976) (en banc). *See also* Iser Elec. Co. v. Fossier Builders, 405 N.E.2d 439, 442 (Ill. App. Ct. 1980) ("The general rule is that agreements to arbitrate will be enforced despite the existence of claims by third parties or of pending multi-party litigation.").

271. Because the patient-third party agreement would not involve a medical malpractice claim, it would have to be made pursuant to, and be valid under, the jurisdiction's general arbitration statute, thus begging the question. Only the Illinois medical malpractice arbitration statute specifically provides for this scenario, stating:

> Additional Parties. By consent of all parties to an arbitration proceeding, a person, corporation, or entity not a signatory to the agreement may be invited to participate in and be bound by the agreement, or may be accepted into the agreement upon an offer to participate and be bound. If such invitation or acceptance is made pursuant to consent of the arbitration parties, no signatory may refuse to arbitrate because of the participation of such additional party. An additional participant shall execute a written statement to be bound by the arbitration proceedings and agreement or shall sign the agreement, and shall then be treated as a party.

Health Care Arbitration Act § 4, ILL. ANN. STAT. ch. 10, § 204 (Smith-Hurd Supp. 1985).

272. Belobradich v. Sarnsethsiri, 346 N.W.2d 83 (Mich. Ct. App. 1983).

273.

ment, but only if they are *necessary* parties.[274] Furthermore, the Illinois statute limits any such joinder to health care providers, hospitals and their employees, or drug and equipment suppliers.[275]

This last qualification should serve to save the Illinois courts from having to decide whether third parties who, for example, fall on[276] or throw snowballs at[277] patients are "necessary" parties. Whether a "health industry" party is a "necessary" party should depend upon whether the claims made against the third party are so "inextricably intertwined"[278] as to preclude determination of the liability issue in that primary claim.[279] Thus, meritless claims or claims against concurrent tortfeasors would not warrant joinder.[280] In contrast, a patient who has submitted a claim under the Michigan statute and who wishes to resist statutory consensual joinder[281] would have to rely upon the more general argument that "the legislature never intended the [arbitrators] to pass upon questions other than that [sic] of medical malpractice."[282]

A person who is not a party to the arbitration agreement may join in the arbitration at the request of any party with all the rights and obligations of the original parties. Each party to an arbitration under this chapter is deemed to be bound by the joinder of a new party.

MICH. COMP. LAWS ANN. § 600.5046(4) (West 1975).

274.

Necessary Parties. A hospital or health care provider, or an employee of a hospital or health care provider, or a supplier, reasonably alleged to be a joint tortfeasor in a cause of action subject to a health care arbitration agreement shall be a necessary party to arbitration binding any of his joint tortfeasors. On application of any party to the arbitration proceeding, the circuit court may stay an arbitration proceeding commenced or threatened on the grounds that a necessary party is not a signatory or party to the agreement. That issue shall be forthwith and summarily tried and a stay ordered if found for the moving party. If found for the opposing party, the court shall order the parties to proceed to arbitration.

Health Care Arbitration Act § 5, ILL. ANN. STAT. ch. 10, § 205 (Smith-Hurd Supp. 1985).

275. " 'Supplier' means a person, corporation, partnership or other entity that has manufactured, designed, distributed, sold, or otherwise provided any medication, device, equipment, service, or other product used in the diagnosis or treatment of a patient." *Id.* § 2(c), ILL. ANN. STAT. CH. 10, § 202(c).

276. Zielinski v. Zappala, 470 F. Supp. 351 (E.D. Pa. 1979).

277. Gillette v. Redinger, 383 A.2d 1295 (Pa. Commw. Ct. 1978).

278. Conklin v. Montefiore Hosp. & Medical Center, 425 N.Y.S.2d 826, 831 (App. Div. 1980) (Lupiano, J., dissenting).

279. *See, e.g.*, Smith v. Linn, 414 A.2d 1106, 1109 (Pa. Commw. Ct. 1980) (joinder not necessary in such cases).

280. Conklin v. Montefiore Hosp. & Medical Center, 425 N.Y.S.2d 826, 830 (App. Div. 1980) (Lupiano, J., dissenting). *See also* Firich v. American Cystoscope Makers, Inc., 482 F. Supp. 1043 (W.D. Pa. 1980); Morrison v. Therm-O-Rite Prods. Corp., 468 F. Supp. 1295 (M.D. Pa.), *aff'd*, 612 F.2d 574 (3d Cir. 1979).

281. *See supra* note 273.

282. Gillette v. Redinger, 383 A.2d 1295, 1298 (Pa. Commw. Ct. 1978).

C. *Claimants*

Statutory schemes permitting voluntary arbitration agreements between a health care provider and a "patient"[283] or "persons asserting a claim"[284] do not appear, on the surface, to present special problems with the identification of persons contractually bound to submit their claims to arbitration. At least three difficult questions arise, however. First, as discussed earlier,[285] a fact-intensive procedural conscionability issue may be raised by a patient who relies upon a specific statutory provision—for example, a provision that prohibits the offer of an arbitration agreement to a patient undergoing emergency treatment,[286] or one that does not permit the enforcement of an agreement made with an illiterate patient.[287] Second, a problem arises in cases in which the patient did not execute the agreement in question; rather, it was executed by a parent or legal representative. Third, there may be difficulties when, although the patient executed the agreement, the claimant is a stranger to the agreement. For example, this would occur when the claim either involves the loss of consortium or is brought under a wrongful death statute and is therefore asserted by a person who did not personally execute the agreement.[288] In answer to the second question, the general rule is that a minor is not bound to submit his claims to arbitration.[289] A majority of malpractice arbitration statutes provide, however, that a parent's execution of an arbitration agreement on behalf of her minor child is binding upon the child.[290] The Illinois statute

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283. ALASKA STAT. § 09-55-535(a) (1983).

284. VT. STAT. ANN. tit. 12, § 7002 (Supp. 1985).

285. *See supra* text accompanying notes 200-02.

286. *See, e.g.*, MICH. COMP. LAWS ANN. § 600.5042(1) (West 1975). *See also* Pipper v. DiMusto, 279 N.W.2d 542 (Mich. Ct. App. 1979).

287. *See, e.g.*, OHIO REV. CODE ANN. § 2711.24 (Baldwin 1984).

288. Consider also a fourth, albeit somewhat rare, scenario. A health care provider executes an arbitration agreement with a *nonpatient* claimant. The claimant tries to avoid submission based on nonarbitrability as a matter of law. The health care provider replies that legal arbitrability exists because a state statute authorizes arbitration of claims against health care providers. The claimant then seeks release from the obligation to arbitrate based on the scope of the statute, as the statute only permits arbitration agreements between *patients* and health care providers. The claimant prevails. *See, e.g.*, Thomasson v. Diethelm, 457 So. 2d 397 (Ala. 1984) (Alabama's Medical Liability Act only contemplates actions brought by members of patient class).

289. *See* Tennessee Coal, Iron & R.R. Co. v. Hayes, 12 So. 98, 103 (Ala. 1892). *See also* Dickson v. Hoffman, 305 F. Supp. 1040 (D. Kan. 1969); Chernick v. Hartford Accident Indem. Co., 187 N.Y.S.2d 534 (App. Div. 1959), *aff'd*, 168 N.E.2d 110 (N.Y. 1960); Britton v. William's Devisees, 20 Va. 453 (1819). *See also* Roberts v. McNamara-Warren Community Hosp., 360 N.W.2d 279 (Mich. Ct. App. 1984) (apparent approval of MICH. COMP. LAWS ANN. § 600.5046 (West 1975)).

290. *See* ALASKA STAT. § 09-55-535(d) (1983); CAL. CIV. PRO. CODE § 1295(d) (West 1982) (codifying Doyle v. Giuliucci, 401 P.2d 1 (Cal. 1965)); Health Care Arbitration Act § 7, ILL. ANN. STAT. ch. 10, § 207 (Smith-Hurd Supp. 1985); LA. REV.

goes so far as to permit a parent who herself is a minor to sign an arbitration agreement that will bind her child![291] Of course, the child sought to be bound to submit to arbitration must have been included within the scope of the agreement. In *Weeks v. Crow*,[292] the plaintiff, who was then pregnant, executed an arbitration agreement in which she alone was described as the patient. Her child died shortly after birth as a result of the alleged negligence of the defendants. In the words of the court,

> [t]he agreement contains no reference at all to the expected child; only the expectant mother is named as the patient. If the parties had intended to agree to arbitration of claims of negligence in treating the child, they could easily have done so by also naming the expected child as a patient. The omission of any reference to the child expresses an intention not to apply the agreement to malpractice claims arising out of medical services rendered to the child.[293]

Thus, in *Wilson v. Kaiser Foundation Hospitals*,[294] a child claiming for his prenatal injuries was forced to submit his claim to arbitration because his mother had executed a health care contract incorporating a malpractice arbitration agreement; the plan included by its terms newborn members of the family.

Only the South Dakota statute expressly provides for arbitration agreements to be executed on behalf of persons incapacitated other than by minority.[295] The absence of statutory authority, however, would not necessarily preclude traditional agency principles from operating. It should be remembered that the fact-intensive litigation that will result will not be supported by any contingent attorneys' fees system[296] and will make something of a mockery of the "speed and econ-

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STAT. ANN. § 9.4231 (West 1983) (implicit from second signature line in nonmandatory sample agreement); MICH. COMP. LAWS ANN. § 600.5046(2) (West 1975); S.D. CODIFIED LAWS ANN. § 21-25B-2 (1979); VA. CODE § 8.01-581.12 (1984) (implicit from revocability provision).

291. Health Care Arbitration Act § 7, ILL. ANN. STAT. ch. 10, § 207 (Smith-Hurd Supp. 1985).

292. 169 Cal. Rptr. 830 (Ct. App. 1980).

293. *Id.* at 832.

294. 190 Cal. Rptr. 649 (Ct. App. 1983).

295.

> "Executors, administrators or personal representatives of an estate and a legally appointed guardian for a ward shall have the authority . . . to enter into a binding arbitration agreement on behalf of the person, estate, beneficiary, ward or heirs at law that they represent . . . ."

S.D. CODIFIED LAWS ANN. § 21-25B-2 (1979) (providing sample agreement).

This should not be confused with provisions permitting legal representatives to *revoke* such agreements. *See, e.g.*, Health Care Arbitration Act § 9(c), ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1985); OHIO REV. CODE ANN. § 2711.23(B) (Baldwin 1984); VA. CODE. § 8.01-581.12.A (1984).

296. This is due to the high claim costs inherent in such cases, which will serve

omy" virtues claimed for arbitration. The case of *Blanton v. Womancare, Inc.*[297] concerned a postclaim malpractice arbitration agreement executed by an attorney purporting to act as his client's agent. In *Blanton*, there was no question of either express actual authority or of agency through ratification, for as the Supreme Court of California noted, "the client did not consent to the agreement; she did nothing beyond retention of the attorney to suggest that he had authority to enter into such an agreement on her behalf; and she repudiated the agreement as soon as she learned of it."[298] Further, the court was of the opinion that an attorney had neither "implied actual" nor "apparent" authority to bind his client to arbitration:

> When a client engages an attorney to litigate in a judicial forum, the client has a right to be consulted, and his consent obtained, before the dispute is shifted to another, and quite different, forum, particularly where the transfer entails the sort of substantial consequences present here.[299]

Different problems arise when the claimant against whom submission to arbitration is sought to be compelled was a "stranger," that is, neither the patient nor a signatory to the arbitration agreement.[300] The general rule governing these cases was expressed by a California appellate court in *Rhodes v. California Hospital Medical Center*.[301] In this case, the health care provider sought to compel the plaintiff's next of kin to arbitrate claims for the wrongful death of a patient who had executed an arbitration agreement. The court stated:

> The right to arbitration depends on a contract. Neither Mr. Rhodes nor the son have ever contracted to forego their rights to have their cause of action determined by a jury in a normal judicial proceeding. Although a wrongful death action must rest on a cause of action in the decedent, we cannot hold that the decedent's agreement to arbitrate *her* possible cause of action is effective to bar the constitutional and procedural rights of the decedent's heirs in their own, independent action.[302]

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to discourage attorneys from bringing marginal or low-yield suits. *See supra* note 6.

297. 696 P.2d 645 (Cal. 1985) (en banc).

298. *Id.* at 649.

299. *Id.* at 653.

300. The distinction between this and the type of case just discussed is addressed in Weeks v. Crow, 169 Cal. Rptr. 830, 832 (Ct. App. 1980).

301. 143 Cal. Rptr. 59 (Ct. App. 1978).

302. *Id.* at 61 (citation omitted) (emphasis added). This begs the question whether the wrongful death action in issue is one that creates an independent (dependents') cause of action, or merely a derivative (survival type) claim. *See* Ballard v. Southwest Detroit Hosp., 327 N.W.2d 370 (Mich. Ct. App. 1982), *appeal in abeyance*, 334 N.W.2d 375 (Mich. 1983) (presumably, the pending constitutional issue was resolved in Morris v. Metriyakool, 344 N.W.2d 736 (Mich. 1984)).

Of course, if the decedent had been the agent[303] for the next of kin (for example, the father or spouse) and had *contracted* with the health care provider that the *next-of-kin's* causes of action would be arbitrated, the opposite conclusion is supportable.[304]

In *Herbert v. Superior Court*,[305] however, a California appellate court apparently lost sight of the contractual, consensual nature of arbitration. In that case, the appeals court compelled the arbitration of wrongful death claims brought by adult children who had not been made beneficiaries of the group health agreement executed by their father, the decedent. The court said that it would be contrary to legislative intent to permit a single cause of action to be split between arbitration of the claims made by the spouse and minor children of the decedent and litigation of the claims made by the adult children. The court noted that "[i]t would be illogical to construe these statutory provisions to apply only under the fortuitous circumstances that *all* potential heirs are also plan members."[306] Why should a court consider it at all "fortuitous" that one person should enter into a consensual agreement when another does not? Such a characterization reveals the inherent difficulties the courts have faced in grappling with the issue of who the proper claimants are in an arbitration-infected malpractice claim.

One might speculate that many of the recent problems encountered by the California courts have stemmed from what appears to be a basic fallacy in the oft-cited decision in *Madden v. Kaiser Foundation Hospitals*.[307] The Supreme Court of California held in *Madden* that a government employee was bound by a malpractice arbitration clause inserted into a group health plan negotiated between a health care provider and the representatives of government employers.[308] As a matter of *labor* arbitration law, a nonparty to a collective bargaining agreement may occasionally be bound by an arbitration clause in that agree-

303. *See, e.g.*, Madden v. Kaiser Found. Hosps., 552 P.2d 1178 (Cal. 1976) (en banc) (state organization was agent for state employee in negotiation of health plan including arbitration clause). *See also* Dinong v. Superior Court, 162 Cal. Rptr. 606 (Ct. App. 1980); LA. REV. STAT. ANN. § 9:4231 (West 1983). Louisiana's sample agreement provides that the *patient* agrees that claims by his heirs shall be submitted to arbitration. Does this imply that the patient is his heirs' agent as a matter of law, or must that be established on a case-by-case basis?

304. *See* Hawkins v. Superior Court, 152 Cal. Rtpr. 491, 494-95 (Ct. App. 1979) (wife required to arbitrate claim involving death of husband, pursuant to health care contract entered into by husband).

305. 215 Cal. Rptr. 477 (Ct. App. 1985).

306. *Id.* at 482.

307. 552 P.2d 1178 (Cal. 1976) (en banc).

308. Note, however, that in Dinong v. Superior Court, 162 Cal. Rptr. 606, 610 (Ct. App. 1980), the court refused to interpret *Madden* and Wheeler v. St. Joseph's Hosp., 133 Cal. Rptr. 775 (1976), as requiring employee elected representatives to be involved in the employer/group health provider negotiations.

ment.[309] The court in *Madden*, however, surely took an extra, unwarranted step in holding that a nonparty could be bound by an arbitration clause contained, not in the collective bargaining agreement, but in a commercial contract between the "union" (the government employer representative in *Madden*) and a supplier of services. Such a position seems contrary to *commercial* arbitration law.[310]

D. *Conduct of Health Care Providers*

Instituting a scheme for the arbitration of medical malpractice claims depends, of course, upon the determination of what constitutes a medical malpractice claim. The Louisiana and Vermont legislative draftsmen were apparently content to leave that issue open.[311] Some draftsmen, however, have embellished that basic concept without adding anything of substance.[312] Other legislative draftsmen have attempted further to refine the components of medical malpractice claims, but have succeeded in doing nothing more than adding question-begging exclusions.[313] Still others have attempted to narrow the type of conduct susceptible to arbitration by referring to "professional negligence,"[314] or to negligent "care or treatment."[315]

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309. *See e.g.*, Pine Mfg. Co. v. International Ladies Garment Workers Union, 383 N.E.2d 543 (Mass. App. Ct. 1978).

310. *See, e.g.*, Al-hadad Bros. Enters. v. M.S. Agapi, 551 F. Supp. 956 (D. Del. 1982).

311. LA. REV. STAT. ANN. § 4231 (West 1983) provides in its nonmandatory specimen agreement that "[c]laims based on negligence or medical malpractice . . . shall be submitted to arbitration," while VT. STAT. ANN. tit. 12, § 7002(a) (Supp. 1985), covers any "claim based on medical malpractice."

312. ALA. CODE § 6-5-485(a) (1975) is phrased in terms of the rendering of, or the failure to render, services by a health care provider. This provision is contained, however, in the Alabama Medical Liability Act, which defines "Medical Liability" as "[a] finding by a[n]. . . arbitration panel that a . . . health care provider did not meet the applicable standard of care." ALA. CODE § 6-5-481(9) (1975). *See* S.D. CODIFIED LAWS ANN. § 21-25B-1 (1979) ("relating to services provided" implicitly restricts arbitrable services to matters within the competency of physician or hospital administrator arbitrators).

313. *See* Health Care Arbitration Act § 2(d), ILL. ANN. STAT. ch. 10, § 202(d) (Smith-Hurd Supp. 1985) (" 'Health Care Arbitration Agreement' [includes] . . . a claim for damages arising out of . . . [injuries or death], due to hospital or health care provider negligence or other wrongful act, but not including intentional torts.").

314. *See* CAL. CIV. PRO. CODE § 1295(a) (West 1982) ("[a]rbitration of any dispute as to professional negligence"); § 1295(g)(2) (" 'Professional negligence' means a negligent act or omission to act by a health care provider in the rendering of professional services."). *See also* MICH. COMP. LAWS ANN. § 600.5040(1) (West 1975) ("[i]njury . . . caused by an error, omission, or negligence in the performance of professional services by a health care provider, hospital, or their agent, or based on a claimed performance of such services without consent, in breach of warranty, or in violation of contract"); VA. CODE § 8.01-581.1.5 (1984) (" 'Malpractice' means any tort based on health care or professional services rendered, or which should have been rendered, by a

The deterrence function of tort law and, *a fortiori*, intentional tort law, will serve to cast doubts upon the survivability of an agreement following judicial scrutiny of its arbitrability as a matter of law. The courts, therefore, will be faced with a multitude of motions either to stay or to compel arbitration to secure judicial rulings on the legality or validity of the arbitration agreements.

Depending upon the statutory language, several difficult problems arise. First, while a claim phrased in terms of breach of contract by the health care provider would clearly be "a dispute arising out of care or treatment," would it also be "professional negligence" or "medical malpractice"? Such a claim, based as it is on the breach of an implied warranty of reasonable professional diligence in the patient-health care provider contract, has been characterized by some courts as merely duplicative of a tort claim.[316] Further, there is authority to the effect that "malpractice" includes these contractual counts.[317] The Michigan statute[318] goes even further, if it is interpreted to include *express* warranty claims[319] under its arbitration regime.

Even if the plaintiff's claim is phrased in terms of tort, it must be recognized that not all torts are created equal. While informed consent is clearly a "malpractice" or "professional negligence" tort, the same cannot be said of a battery action based on lack of consent rather than inadequate information.[320] Thus, without specific statutory elucidation

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health care provider, to a patient."); VA. CODE § 8.01-581.1.6 (1984) (" 'Health care' means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical diagnosis, care, treatment or confinement.").

315. *See* ALASKA STAT. § 09-55-535(a) (1983) ("[a]ny dispute, controversy, or issue arising out of care or treatment by the health care provider"); GA. CODE ANN. § 9-9-110 (1981) (" 'Medical malpractice claim' shall mean any claim for damages . . . arising out of: (1) Health, medical, dental or surgical service, diagnosis, prescription, treatment, or care rendered by a licensed [health care provider], . . . or (2) Care or service rendered by any [institutional health care provider]."); OHIO REV. CODE ANN. § 2711.22 (Baldwin 1984) ("[a]ny dispute or controversy arising out of the diagnosis, treatment, or care rendered").

316. *See, e.g.*, Woolley v. Henderson, 418 A.2d 1123 (Me. 1980).

317. *See, e.g.*, State *ex rel.* Sisters of St. Mary v. Campbell, 511 S.W.2d 141 (Mo. Ct. App. 1974).

318. MICH. COMP. LAWS ANN. § 600.5040(1) (West 1975) ("in breach of warranty, or in violation of contract").

319. *See* Brown v. Rabbit, 476 A.2d 1167 (Md. 1984) (express warranty claim covered by Maryland's mandatory pretrial arbitration statute). *See generally* Note, *Express Contracts to Cure: The Nature of Contractual Malpractice*, 50 IND. L.J. 361 (1975).

320. *See* Mink v. University of Chicago, 460 F. Supp. 713, 716-18 (N.D. Ill. 1978). *See also* Hodge v. Lafayette Gen. Hosp., 399 So. 2d 744 (La. Ct. App. 1981) (interpreting Louisiana's compulsory pretrial review panel trigger of "unintentional tort" as covering an informed consent allegation); Lubanes v. George, 435 N.E.2d 1031 (Mass. 1982) (claim based on informed consent subject to medical malpractice tribunal

of whether such intentional tort claims are[321] or are not[322] arbitrable, the issue will invite litigation.[323]

Similar problems arise when the plaintiff seeks to avoid submission to arbitration by characterizing her claim in terms of strict liability, such as products liability rather than negligence. It may be countered that this should be of no concern since, even if such a claim is not arbitrable, the health care provider will not be held strictly liable for professional "negligence."[324] This ignores, however, that narrow range of cases in which, for example, a hospital is in reality introducing a product into the stream of commerce.[325] Even if such a claim were to be construed as a controversy arising out of care or treatment,[326] a court should nevertheless conclude that, "[t]he expertise of the arbitration panel . . . relates to medical liability, not products liability."[327]

States that have defined the limits of malpractice arbitrability in terms of "professional negligence,"[328] presumably exclude from submission claims dealing with "nonprofessional negligence," such as collapsing equipment[329] or slips and falls.[330] Those premises liability cases, however, are among the clearer cases for a court to deal with when a plaintiff seeks to use an "ordinary negligence" standard. For a mal-

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submission statute).

321. *See* MICH. COMP. LAWS ANN. § 600.5040(1) (West 1975).

322. *See* Health Care Arbitration Act § 2(d), ILL. ANN. STAT. ch. 10, § 202(d) (Smith-Hurd Supp. 1985).

323. *See, e.g.*, Baker v. Sadick, 208 Cal. Rptr. 676, 681 (Ct. App. 1984) (language of agreement about non-negligent claims to be considered in conjunction with statutory terms); Nichols v. Wilson, 460 A.2d 57, 60-61 (Md. 1983) (battery claim not covered by Maryland's mandatory arbitration scheme). *Cf.* Herrera v. Superior Court, 204 Cal. Rptr. 553, 557-58 (Ct. App. 1984) (patient's allegations of provider assault and battery were subject to arbitration in lieu of grounds for revocation).

324. *See, e.g.*, Hershley v. Brown, 655 S.W.2d 671 (Mo. Ct. App. 1983).

325. *See, e.g.*, Thomas v. St. Joseph Hosp., 618 S.W.2d 791 (Tex. Ct. App. 1981). *See generally* Note, *The Medical Profession and Strict Liability of Defective Products—A Limited Extension*, 17 HASTINGS L.J. 359 (1965).

326. *See, e.g.*, Renz v. Ochsner Found. Hosp./Clinic, 420 So. 2d 1008, 1009 (La. Ct. App. 1982).

327. Geisinger Medical Center v. Fisher, 413 A.2d 462, 464 (Pa. Commw. Ct. 1980) (in context of medical care provider's petition for joinder of product manufacturer under Pennsylvania's mandatory arbitration scheme).

328. *See supra* note 314.

329. *See, e.g.*, Cannon v. McKen, 459 A.2d 196 (Md. 1983). *Cf.* Walsh v. LoPiccolo, 485 N.Y.S.2d 946 (Sup. Ct. 1985) (treatment-related claims still must be placed before arbitration panel).

330. *See, e.g.*, Head v. Erath Gen. Hosp., 458 So. 2d 579 (La. Ct. App. 1984); Cashio v. Baton Rouge Gen. Hosp., 378 So. 2d 182, 185 (La. Ct. App. 1979). *Cf.* Rothman v. Sacred Heart Hosp., 13 Pa. D. & C.3d 496 (Pa. C. 1979) (interpreting broadly a claim resulting from the furnishing of health care services). *See also* Nemzin v. Sinai Hosp., 372 N.W.2d 667 (Mich. Ct. App. 1985) (interpreting the Michigan arbitration statute, which is phrased in terms of "dispute, controversy, or issue arising out of health care or treatment," as including a fall from bed).

practice arbitration statute to use "professional negligence" or even "medical malpractice" terminology invites exposure to the full range of judicial sophistry associated with the conclusory medical-ministerial characterization.[331] Since the purpose of that characterization is to distinguish between cases that require expert testimony and those that do not, a provision in the arbitration statute to the effect that expert testimony is not always required[332] has the effect of extending the arbitrators' jurisdiction.

E. *Punitive Damage Claims*

State arbitration statutes are silent on the issue of recoverable damages. This is no doubt due partially to the fact that those same statutes seem to suggest that the determination of damage quantum rests solely with the arbitrators. Submission of a case to arbitration that involves a claim for punitive damages, however, raises several diffi-

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331. *See, e.g.*, Meier v. Ross Gen. Hosp., 445 P.2d 519 (Cal. 1968) (en banc). For cases decided in the context of mandatory pretrial arbitration or review, see Wyble v. St. Luke Gen. Hosp., 415 So. 2d 622 (La. Ct. App. 1982); Herr v. St. Francis Hosp., 9 Pa. D. & C.3d 610 (Pa. C. 1978).

In Hedlund v. Superior Court, 194 Cal. Rptr. 805 (1983), the Supreme Court of California interpreted "professional negligence," as used in that state's Medical Injury Compensation Reform Act (which includes that state's malpractice arbitration provisions), as not to be limited to the physician-patient relationship, but to include the breach of a duty to warn a nonpatient. The implication is that "professional negligence" will be interpreted as "negligence" by a (medical) "professional." *Id.* at 807-10. For a recent example of the degree of judicial manipulation possible in such cases, see Victoria v. Superior Court, 222 Cal. Rptr. 1 (1985). An arbitration clause in a group health plan applied by its terms to claims "arising out of service rendered (or not rendered) pursuant to the Agreement." Noting that ambiguities in the agreement would be interpreted against the health care provider, the majority of the Supreme Court of California was of the opinion that

> [p]etitioner's claims involve neither financial disputes nor medical malpractice. Instead, she alleges a breach of the common law duty of an employer to exercise due care in the employment and supervision of an employee who inflicted intentional harm on her. . . . Furthermore, the employee's alleged misconduct was entirely outside the scope of his employment. It had nothing to do with providing, or failing to provide, services. He is not accused of negligently failing to empty a bedpan. He is accused of the sexual assault and rape of petitioner.
>
> Surely it was not contemplated, let alone expected, by either party to the Agreement that this sort of attack would befall petitioner while she was hospitalized under Kaiser's care. It is, therefore, difficult to conclude that the parties intended and *agreed* that causes of action arising from such an attack would be within the scope of the arbitration clause.

Id. at 7 (emphasis in original) (citation omitted). For Judge Lucas, in dissent, the majority's characterisation of the issue was transparent. "By improperly focusing only on the employee's conduct, rather than on the actual claim against Kaiser, the majority has strained to find ambiguity where none exists." *Id.* at 10 (Lucas, J., dissenting).

332. *See, e.g.*, VT. STAT. ANN. tit. 12, § 7006 (Supp. 1985).

cult questions.[333]

First, a claim for punitive damages usually is premised upon the plaintiff's proving "that the defendant's conduct was willful or wanton, in a reckless disregard of rights or interests."[334] Thus, the plaintiff's claim in such a case is similar to a count expressed in intentional tort law, a species of claim that not all malpractice arbitration statutes expressly include as arbitrable.[335]

Second, the deterrence function of a punitive award highlights difficult questions about the statutory scope of arbitrability. Since the malpractice statutes omit express references to such claims, the courts may well turn away from their general policy of favoring arbitration. If a punitive damages claim changes the nature of the action from a merely private dispute, it would cause serious practical difficulties. If the compensatory claim had to be submitted to arbitration, but the punitive claim could be litigated, the proceedings would be duplicated rather than streamlined—thus negating one of the ostensible purposes of the arbitration agreement.[336]

The argument that the strong public policy interest in the deterrent role of punitive damages should overcome private agreements on their reallocation is analogous to the issue of the insurability of damage claims.[337] Although it is often asserted that the policy behind punitive awards "would be frustrated if a tortfeasor were allowed to insure himself against an award of punitive damages,"[338] many states nevertheless do permit such contractual reallocation. The commonly supplied rationale for deviation from the general rule is that "[t]he interests of doctors and patients alike can best be served by medical malpractice insurance that protects the doctor and patient, even when the doctor's negligence is wanton or gross."[339] In these jurisdictions, therefore, the individualized deterrence function of the punitive damage award is outweighed

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333. *See generally* Note, *Awarding Punitive Damages in Medical Malpractice Arbitration*, 20 CAL. W.L. REV. 312 (1984). *See also* Bishop v. Holy Cross Hosp., 410 A.2d 630, 631-32 (Md. 1980) (plaintiff claiming punitive damages *must* exhaust contracted-for arbitration device before invoking a court's jurisdiction); Note, *Punitive Damages in Arbitration: The Search for a Workable Rule*, 63 CORNELL L. REV. 272 (1978).

334. Brown v. Maxey, 369 N.W.2d 677, 681 (Wis. 1985) (citation omitted).

335. *See supra* text accompanying notes 321-22. More specifically, consider Nichols v. Wilson, 460 A.2d 57 (Md. 1983) (intentional tort claim for, *inter alia*, punitive damages).

336. *See, e.g.*, Herbert v. Superior Court, 215 Cal. Rptr. 477 (Ct. App. 1985) (submission to arbitration compelled to avoid splitting of cause of action in wrongful death claim brought by both members and nonmembers of group health plan).

337. *See* Burrell & Young, *Insurability of Punitive Damages*, 62 MARQ. L. REV. 1 (1978).

338. Aetna Life & Casualty Co. v. McCabe, 556 F. Supp. 1342, 1356 (E.D. Pa. 1983).

339. Mazza v. Medical Mut. Ins. Co., 319 S.E.2d 217, 221 (N.C. 1984).

by the more probable satisfaction of its "compensation" function upon efficient reallocation through insurance spreading.

This rationale does not transfer readily to the arbitration arena. Clearly, the deterrence goal of an award may be ignored by an arbitration panel less willing to characterize medical carelessness as "reckless." Further, the general deterrence[340] role of any punitive award may be negated because the hearing and award will lack publicity. Yet in the arbitration context, this diminution of the deterrence function will be *in addition* to a less likely (or lesser) award of punitive damages and not the *quid pro quo* for the guaranteed payment of a punitive damages judgment.

The only reported decision involving a punitive award following voluntary arbitration of a medical malpractice claim resulted, ironically, from a health care provider's challenge of the award. In *Baker v. Sadick*,[341] a physician challenged a $300,000 punitive award in a case that had been submitted to arbitration on both negligence and intentional tort grounds. In upholding the award against the physician, the California appellate court paid scant attention to the physician's argument that arbitration was an inappropriate source for the award of a penalty. This case, however, does not establish that a patient cannot resist submission of a claim seeking punitive damages to arbitration. First, the clear implication of the physician's argument in *Baker* was that the arbitrators had exclusive jurisdiction over this type of medical malpractice claim. The argument was not phrased in terms of dealing with the compensatory claims in arbitration, but rather with the punitive claims in litigation. The physician was attempting to have his cake and eat it too.[342] Second, in interpreting the agreement, the court did not take the standard *contra proferenten* approach that ambiguities would, in this case, be resolved against the patient. Instead, the court labelled the agreement a contract of adhesion, then focused on the unequal bargaining position of the parties and resolved the ambiguities in

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340. *See* G. CALABRESI, *supra* note 121, at 68-94. *See also* Calabresi, *Optimal Deterrence and Accidents*, 84 YALE L.J. 656 (1975); Calabresi & Hirschoff, *Toward a Test for Strict Liability in Torts*, 81 YALE L.J. 1055 (1972).

341. 208 Cal. Rptr. 676 (Ct. App. 1984).

342. Or, more precisely:

> [The physician] also claims the public policy favoring arbitration will be frustrated if arbitrators are permitted to award punitive damages. [The physician] asserts punitive damages are a form of penalty reserved for imposition by the state. Therefore, he argues, contracts which provide for private penalties are unenforceable. It is further urged punitive damages awards made in civil actions are subject to judicial review and since arbitration awards including punitive damages are not reviewable, agreements to arbitrate will be discouraged.

Id. at 683.

favor of the patient.[343] And of course, in this case, the patient had no quarrel with the wide scope attributed to the agreement by the arbitrators.[344] Third, the court suggested that a patient's motion to stay arbitration would be treated more favorably in this context than a physician's challenge to a jointly submitted award.[345]

X. CONCLUSION

In summary, state legislatures that have facilitated the arbitration of medical malpractice claims have thrust a multitude of new and difficult legal issues onto their courts' overcrowded dockets. Are such statutory provisions constitutional? What degree of judicial control over the bargaining process will suffice to ensure that any arbitration is voluntary? Which of the many different species of litigation concerning medically related injuries will be subject to arbitration? At the very least, the opponents of "speedy and economical" medical malpractice arbitration will have the satisfaction of knowing that the legal problems inherent in existing state facilitated and encouraged systems will guarantee complex and expensive litigation for years to come. Such problems could have been avoided if the philosophy of alternate dispute resolution and the traditions of arbitration had not been ignored by legislatures apparently willing to do anything to satisfy the complaints of the health care and insurance industries. In the first place, alternate dispute resolution systems are just that—alternatives, not blanket substitutes. In the second place, the historically voluntary nature of arbitra-

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343. *Compare* the *Sadick* court's appeal *with* CAL. CIV. PRO. CODE § 1295(e) (West 1982) (providing that a contract which includes an arbitration clause "is not a contract of adhesion" when statutory requirements are met).

344. Specifically, the court found that

> [f]rom the face of the statute and the agreement, it appears: Neither the statute nor the agreement specifically mention or authorize [sic] a claim for punitive damages. In fact, the definition of "professional negligence" appears to limit the recovery to a "negligent act or omission." This latter language . . . creates an uncertainty, an ambiguity. Here, it is not the weaker party, [the patient], who seeks to limit the arbitration settlement. Rather, it is [the physician] who seeks to escape the broad embrace of the general terms of the arbitration agreement. In this context we construe the language favorable to [the patient]'s (the nondrafter's) position.

208 Cal. Rtpr. at 681.

345.

> This is not a case where the doctor alone insists upon submitting the patient's claim for punitive damages to arbitration. Whether such request is supported by the ambiguous language of this agreement is not before us. In this case it is the patient as well as the doctor who have submitted this intentional wrong, fraud, punitive damages claim to the arbitrators. Having consented to this submission, the doctor may not now assert a lack of authority in the arbitrators to award punitive damages.

Id.

tion is deserving of respect. Any state legislature contemplating the introduction of malpractice arbitration should consider restricting it to postclaim agreements so that the voluntary nature of arbitration will not be destroyed by health care providers with their pretreatment standard form contracts. Given time, such arbitration could win the acceptance and participation of the bar and the medical profession. Furthermore, any such facilitating legislation should target situations in which the traditional virtues of arbitration such as speed and economy would bring real advantages. By way of example, consider the benefits that would accrue to elderly nursing home residents if their claims against their institutions could be resolved by arbitrators.

Yet whatever the philosophical, distributional, and technical problems with the current brand of malpractice arbitration, its time may well have arrived. It seems unlikely that the courts will stand in its way.[346] Judges know that they, too, are not immune from blame for the existence of a malpractice crisis. As the late Judge Tobriner, once a champion of expanded provider liability,[347] stated,

> [u]nder the aegis of permissive legislation and favorable judicial decisions, arbitration has become a proper and usual means of resolving civil disputes, including disputes relating to medical malpractice. We should not now turn the judicial clock backwards to an era of hostility toward arbitration. We should not fetter that institution with artificial requirements . . . . We should not impose debilitating obstructions, such as those urged by plaintiffs, which could very well jeopardize the legality of the huge number of presently functioning and efficacious arbitration agreements.[348]

In permitting the arbitration of medical malpractice claims, however, the courts will in effect be consigning malpractice law and the standards expected of the medical profession to a time capsule. Arbitrators will not entertain novel claims. Health care providers will change their ways, if at all, only because of dubious market and marketing considerations. The successors of Judge Learned Hand may still

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346. *See* Henderson, *supra* note 2, at 997 ("[T]he courts are not really free to engage in distrust of the arbitration process at this point in time and history."). *See also* Southland Corp. v. Keating, 465 U.S. 1 (1984) (contracts to arbitrate may not be avoided by allowing one of the parties to ignore the agreement and resort to the courts).

347. *See, e.g.*, Thompson v. County of Alameda, 614 P.2d 728, 738-42 (Cal. 1980) (en banc) (Tobriner, J., dissenting); Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 339 (Cal. 1976) (en banc) (Tobriner, J., writing for the majority); Clark v. Gibbons, 426 P.2d 525, 535-40 (Cal. 1967) (en banc) (Tobriner, J., concurring).

348. Madden v. Kaiser Found. Hosps., 131 Cal. Rptr. 882, 892 (1976) (en banc). *Cf.* Davis v. Blue Cross, 600 P.2d 1060, 1063-64 (Cal. 1979) (en banc) (insurer has duty to inform insureds of the availability of, and the procedures necessary to utilize, arbitration).

assert that "[c]ourts must in the end say what is required,"[349] but they will be bereft of the jurisdiction to give effect to that principle. Courts that once successfully demolished the "Balkanization"[350] of the medical profession will have abetted its enthusiastic embrace of stasis.

349. The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932).
350. *See* Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968).